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# Depression Among the Oneida: Case Studies of the Interface Between Modern and Traditional

Mark R. Powless  
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DEPRESSION AMONG THE ONEIDA: CASE STUDIES OF THE  
INTERFACE BETWEEN MODERN AND TRADITIONAL

by

Mark R. Powless, M.S.

A Dissertation submitted to the Faculty of the Graduate School,

Marquette University,

in Partial Fulfillment of the Requirement for

the degree of Doctor of Philosophy

Milwaukee, Wisconsin

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## ABSTRACT

### DEPRESSION AMONG THE ONEIDA: CASE STUDIES OF THE INTERFACE BETWEEN MODERN AND TRADITIONAL

Mark R. Powless, M.S.

Marquette University, 2009

Depression, defined by a EuroAmerican biomedical diagnostic criterion, using the Diagnostic and Statistical Manual of Mental Disorders-Fourth Edition, Text Revision is prevalent among First Nations peoples. However, some studies suggest that the term *depression* may hold little heuristic value outside of its EuroAmerican conceptualization. This study utilized qualitative methods to understand how depressive symptoms are conceptualized and experienced by traditional Oneida people. A vignette was presented and in-depth interviews of seven traditional healers, culture and Oneida language experts were conducted to: (1) gain a basic understanding of traditional views of mental health, (2) acquire multiple conceptualizations of someone who presents with DSM-IV-TR symptoms of Major Depressive Disorder including possible causes and treatment, and (3) understand depressive symptoms, as perceived by traditional healers and culture bearers, affects the functioning of the community. Healers set the stage to determine whether the diagnostic label of *depression* holds heuristic value within the culture and is useful for conceptualizing and treating a patient's symptoms of distress within a traditional cultural counseling setting. The results contribute knowledge about one traditional First Nation's conceptualizations of *depression* as a diagnostic label and extend a framework for understanding cultural and local idioms for mental health concepts such as depression.

## ACKNOWLEDGEMENTS

Mark R. Powless, M.S.

Watkunuwela·tú swekwe·kú. OnΛyoteʔa·ká ní·í. **Wakkwáho** niwakitaló·tΛ, **ohkáleʔ** Tehaliwaʔkháhshyusus niyúncyats. YawΛʔkó ne kwatsí·le áksohta, Erma, aknúlha, Mary, khekstΛha, Terri, kheyΛha Kawelatsatste ok Niki, ohkáleʔ iyÁha LanlatÁtha. YawΛʔkokiwa·né Shunkwayaʔtísu **ohkáleʔ** akwe·kú. Special thanks also to everyone who assisted me with this project including the participants, OnΛyoteʔa·ká community assistants, the dissertation committee, and those who proofread the document. I also want to acknowledge the contributions of family and friends who have managed to be patient and supportive throughout this doctoral journey. More special thanks to academic friends including Leah, Lisa, and Tassy, who without their support, I may not have begun and certainly would not have completed this process. I also offer my humblest gratitude to everyone and everything that has assisted and strengthened me including the OnΛyoteʔa·ká culture and my dog.

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## CHAPTER 1.

### Introduction

*"The world in which you were born is just one model of reality. Other cultures are not failed attempts at being you: they are unique manifestations of the human spirit."*  
Wade Davis – Anthropologist

Native American Indians in general are consistently overrepresented among the worst health statistics. This includes mental health. However, few attempts have been made to understand whether Western health statistics based on Western diagnostic systems hold the expected meanings for Native American Indian peoples. The fact that there are hundreds of different First Nations, who have distinct cultures, causes the generalization of research findings about these meanings of diagnosis to be problematic. In order to begin to explore a translation of meaning across the Western and Native American Indian systems, this study focused on Oneida people who hold a traditional Oneida worldview. Traditional Oneida culture is presented as a backdrop to understanding some historical and contemporary context for this study. Insight into the culture will aid with understanding an Oneida view of mental health and illness. The Oneida culture is based in oral history beginning before a time that anyone remembers. Some of this history has since been written, while many pieces are not fully understood until they are heard with an ear for the particular expressions found only within the Oneida language. The cultural beliefs are founded in a time and place where joy and fulfillment were everywhere and unhappiness, disputes and dismay were unknown. The culture is anchored in assisting others and maintaining the original instructions of living in a peaceful and harmonious manner with everything in creation, while acknowledging

that mankind is but one part of what makes up this world. The Oneida Creation story tells a tale of sacrifice for the greater good and what can come out of good intentions. It also tells of the power of love, compassion, and selflessness. There are instructions about how to live a good life and live in the happy and plentiful manner that was intended. There are also warnings about the negativity created when creatures proceed with bad intentions and act in disharmonious ways. The ceremonies given to the Oneida are meant to engender better minds and provide the path to peace and harmony.

This cultural backdrop along with information specific to Oneida healing beliefs was applied to a vignette that would be diagnosed as depression by a Western-trained mental health professional. This was done in an effort to determine points of convergence and divergence between the traditional Oneida and Western Diagnostic and Statistical Manual of Mental Disorder, Fourth Edition-Test Revision (DSM-IV-TR)-based systems of understanding mental health, illness and depression specifically.

An exploration beginning with the views of traditional Oneida people may lead to a better understanding of their experience with psychological distresses including major depression, which will inform theories about etiology and treatment. Specific risk and protective factors as well as premises for illness prevention are afforded. This exploration requires an attempt to understand how traditional Oneida view the world. Understanding a culture's worldview will provide insight into how they describe and interpret experiences with mental health including major depression (Canino, Lewis-Fernandez, & Bravo, 1997; Rogler, Malgady, & Rodriguez, 1989). Worldview was uncovered by interviewing traditional healing persons and cultural and language experts to determine the points of convergence and divergence between traditional Oneida and

DSM-IV-TR conceptualizations of Major Depressive Disorder, including causes, treatment and community impacts. The results of this study have implications for furthering a framework for understanding cross-cultural work in and for assisting with appropriate interpretation of the psychological experiences of the traditional Oneida.

Extended Case Method (ECM) (Burawoy, 1998; Burawoy, Burton, Ferguson, & Fox, 1991) was used as the method of study. ECM allows the use of culturally congruent methods to study existing and emerging phenomenon, including semi-structured individual interviews with cultural experts conducted by an insider-expert. Furthermore, ECM does not necessarily link existing theory with the method of gathering data and allows inductive and deductive interpretation of data in order to reconstruct existing theory while being sensitive to emerging and culturally specific explanations.

### *A Call From the Cross-Cultural Field*

Many believe there is a great need for a cross-cultural approach to mental illness and psychotherapy treatment. Those who have indicated this need also note that despite the potentially high value of information obtained through this approach there is a notably great lack of useable literature that delves into the application of theory to clinical work with specific First Nations (American Psychiatric Association, 2000; Duran & Duran, 1995; Kleinman & Good, 1985; Manson, Shore, & Bloom, 1985; O'Neill, 1989). A cross-cultural approach will enable greater sensitivity by the clinician along with greater competency and ability to better understand each client within the context of his or her specific worldview. It would be a gargantuan if not impossible task to research and report on each and every culture around the globe. In addition, intra-cultural variations indicate that generalization even within specific cultures may not result in an



accurate conceptualization of the individual client (Kleinman, 1988). However, the application of a cross-cultural approach is valuable to reach each individual client, as he or she understands the world and their current psychological problem. It is thought that this will enable the clinician to better tailor treatments to fit within the client's understanding and conceptualization so that treatment will be more effective and durable (Gaines, 1992; Ibrahim, 1991; Lefley, 1999; Manson, 1995; Sue, 1978; Sue, Ivey, & Pedersen, 1996; Sue & Sue, 1999).

This project is significant because psychological problems, including depression, are diagnosed at a much higher rate among Native American Indians than other ethnic populations. In addition, Native American Indians remain one of the most underserved populations in mental health (National Institute of Mental Health, 1987; U. S. Commission on Civil Rights, 2004). A review of the literature revealed that research investigating the nuances of mental health with Native American Indian populations is lacking. In addition, existing theories of mental health and illness among Native American Indian populations are not substantive enough to provide an adequate understanding to change the current condition.

The current study concentrated on the mental illness conceptualized by the mainstream DSM diagnosed Major Depressive Disorder. Depression is a label used variously by laypersons and professionals. The DSM-IV-TR (APA, 2000) definition and diagnostic criteria for major depression will be used in this project because the DSM-IV-TR is the most recent revision of the manual and it is the standard used by professionals within a EuroAmerican mental health care system. Depression is a problem that many think is universal across the globe, and it is widely diagnosed across cultures (Gotlib &

Hammen, 2002; Kleinman & Good, 1985). However, it has yet to be determined whether major depression is indeed universal, or if the DSM-IV-TR criteria for major depression are able to accurately capture that concept using non-EuroAmerican worldviews. In an effort to better understand other cultures' conceptualization of *depression*, this study focused on the traditional Oneida. This study utilized semi-structured individual around a DSM casebook vignette of major depressive disorder and DSM-IV-TR diagnostic constructs.

An introduction of the vignette used in this study and a review of literature pertaining to the Western-based diagnostic manual for mental disorders and the impacts of depression on mainstream and Native American Indian societies follows. In addition, concepts of worldview and their application to mental health are reviewed. Native-centric explorations of general views of mental health and Oneida specific literature are reviewed. Furthermore, previous studies relevant to this project are critically reviewed.

### *Vignette*

A vignette of major depressive disorder was adapted from an abnormal psychology casebook (Getzfeld, 2004) (Appendix C). The case example was designed to have symptoms from each of the four areas for diagnosis of Major Depressive Disorder including (1) affect, as in feeling sad, (2) behaviors, with psychomotor changes and not engaging in previously enjoyable activities, (3) cognition, with thoughts of death and worthlessness, as well as concentration and decision-making problems, and (4) somatization, including appetite and sleep changes (Manson, Shore, & Bloom, 1985).

The vignette, discussed further in the method section, meets the DSM-IV-TR diagnostic criteria for major depressive disorder (Appendix E). The vignette includes the

hallmark features of depressed mood and lack of enjoyment and the minimum two-week duration. The case presents two symptoms related to cognition (difficulty with attention and thinking that life is not worth living), two symptoms related to affect (sad and empty/hopeless), two symptoms related to behaviors (crying, not having fun) and two somatic symptoms (poor appetite and drained energy).

The traditional Oneida culture will be presented next as an introduction and backdrop to their worldview. A basic understanding of the Oneida culture will assist with gaining insight into their conceptualization of mental health, illness and *depression*. This will set the stage for understanding the interview responses and interpretation of the data.

### *Traditional Oneida Culture*

The Oneida Nation uses its own language and refers to its citizens as “OnΛyote?a·ká” (Oh-na-yo-day-ah-ga), or “People of the Standing Stone.” This description comes from a story about when they first developed into an independent nation, at a time presumed to occur at least many thousands of years ago, and a large stone came to them as a sign of protection (Shimony, 1994; Wallace, 1994). The traditional OnΛyote?a·ká do have a number of people in the community who provide education in an attempt to prevent and/or treat problems of conflicts, role transitions, and grief. Moreover, there are communities of healers who have been chosen by healing spirits to alleviate physical, mental, emotional and spiritual problems. These traditional ways are based on the roots of OnΛyote?a·ká culture. (Elm & Antone, 2000; Mitchell, Barnes, Thompson, Mitchell, Thomas, & Buck, 1994; Mohawk, 2005; Shenandoah & George, 1998; Shimony, 1994; Sturtevant, 1978).

### *History of the On̓ayoteʔa·ká*

The On̓ayoteʔa·ká are one of the federally recognized Native American Indian First Nations. They are also one of the original five Nations of the Iroquois confederacy. The On̓ayoteʔa·ká are a people who, according to their beliefs, history and sovereign status, are caretakers of their ancestral lands. These lands originally encompassed approximately six millions acres in what is now upstate New York just west of Albany. Since the late 1700's and early 1800's three separate On̓ayoteʔa·ká communities have come to exist. One remains on the ancestral homelands while another was developed in Ontario, Canada approximately one hour east of Detroit. The third community is in Wisconsin bordering with the city of Green Bay. Approximate populations of the three communities include 3,500 living in Ontario, 1,100 in New York state, and approximately 14,500 in the state of Wisconsin. Of the Wisconsin community approximately 5,000 live on reservation land (Josephy, 2002; McLester, Torres, Viola, & Jeffery, 2000; U.S. Census Bureau, 2006). The On̓ayoteʔa·ká, like other First Nations, have their own language, history, and culture.

The confederacy of Five Nations, including the On̓ayoteʔa·ká, banded together to form a powerful force in the northeastern area of what is now the United States and Canada. The word used to indicate the Iroquois confederacy is “Haudenosaunee” or “People of the Longhouse.” This refers to the type of dwelling that was used for residence. All the families of a clan, discussed below, lived in one dwelling. As families expanded room was added onto the ends, which resulted in a long house. The On̓ayoteʔa·ká have nine clans and therefore there were nine longhouses in the old communities. Likewise the Haudenosaunee have 50 clans in total and would have had 50

longhouses scattered throughout their territory. That term also reflects a larger cultural meaning as other First Nations could be added into the confederacy if they adhered to the political mandates. In fact, the Tuscarora were added as the sixth Nation in the early 1700s (Shimony, 1996; Sturtevant, 1978; Wallace, 1994). The terms OnΔyoteʔa·káʔ and Haudenosaunee will be used throughout this paper because they are the terms that are used by the people being discussed herein and because the terms Oneida and Iroquois are mislabels at best and considered imposing or even derogatory by many. It is thought that the terms Oneida and Iroquois are some version or combination of French, English, Dutch, and other First Nation's words that are not always flattering. There is a story that the Europeans encountered the Haudenosaunee from the north and passed through Algonquin territory. The Algonquin and Haudenosaunee were trading rivals, and they have a word similar to Iroquois that translates to mean "snakes" (Tehanetorens, 1998). The word Iroquois has persisted since that time even though we would prefer not to be called a disparaging name.

### *OnΔyoteʔa·káʔ Culture*

*Language.* Understanding concepts within a culture's language will provide insight into their worldview. It has been noted that the OnΔyoteʔa·káʔ language structure allows for expressing much more description and specificity within single words and across concept than the English language. Approximately 85% of the words are considered verbs whereas only approximately 14% of the words are nouns with approximately 1% being particles. The English language places a greater emphasis on nouns and using multiple words to express an idea that is expressed with one word in

Onʌyoteʔa·káʔ (Abbott, 2006; Abbott, Christjohn & Hinton, 1996; Michelson, Doxtator & the Oneida Nation of the Thames Band Council, 2002).

Much emphasis in the Onʌyoteʔa·káʔ language is on relations and this is expressed with verbs. The verbs fall into different categories. There are subjective verbs where there is an action, objective verbs where a state of being is described, and transitive verbs where some type of transaction is going on. The transitive verbs are perhaps the most interesting and the most telling about how Onʌyoteʔa·káʔ people conceptualize the world. Relationships, such as between relatives and objects, are considered transactions with each party having roles and responsibilities to the other. For example, when someone describes their grandmother they are really talking about the transaction of her, the grandmother, having the action of “grandmothering” the speaker. Transactions and relationships also occur with spiritual beings and pieces of creation in addition to people (Abbot, 2001; Abbott, Christjohn & Hinton, 1996; Michelson et al., 2002). This use of transitive verbs allows one to begin to understand how Onʌyoteʔa·káʔ people view many things in the world as if they are in a relationship with those things and each participant in the relationship has a role and a responsibility to uphold.

Most Onʌyoteʔa·káʔ words combine one or more prefixes, one or more suffixes, and a noun root or a verb root or both. The intricacy of combinations is more complex than English, but in this manner most single words convey an entire sentence or even a paragraph of meaning. This structure and flexibility is what allows the language to be very descriptive and specific (Elm & Antone, 2000). The above brief description of Onʌyoteʔa·káʔ language provides a glimpse of how the Onʌyoteʔa·káʔ people view the world and their place within it as intertwined, inter-dependent, and relationship-based.

They express and interpret their place in a highly specific manner that includes many inseparable relationships with people and other important objects within the environment, including forces of nature and spiritual forces, in which all parties uphold specific roles and responsibilities. This seems to be in line with observations by Duran (1990) about Native American Indian people in general who view the world in an active manner by focusing on processes and describing the world predominantly using verbs. Language was given to the On̓ayoteʔa·káʔ people at the time of creation, and the story of creation provides the basis for how the rest of the culture is described and understood. The On̓ayoteʔa·káʔ creation story will now be briefly presented.

*Creation story.* The Creation story has a long history with many details. It has been handed down orally for generations and continues to be told to this day. The story actually begins prior to what will be related here, for this purpose there was a woman who lived in an upper, or sky world as part of a community there. This sky world was a place where sadness and negativity were unknown and it is this manner of living that is intended for the people on this earth. She was called Skywoman and she fell from that world down to the earth, which was covered in water at the time. There were some water animals here at that time including mammals, birds, and reptiles, such as otters, loons, and turtles. The animals saw her falling and some birds went up to catch her. The animals realized that she would need a place to stay on because she would not be able to survive living in the water. A great turtle volunteered to let her stay on its back. The animals also realized that the turtle's back would not be large enough for long-term, and they remembered stories about dirt at the bottom of the water. Several animals unsuccessfully attempted to get the dirt but drowned in the process. Finally, the muskrat

was able to get some dirt. This dirt was placed on the turtle's back and Skywoman worked it around. As she worked it around, it grew and over time it came to form all the earth on this planet (Elm & Antone, 2000; Mitchell, Barnes, Thompson, Mitchell, Thomas & Buck, 1994; Mohawk, 2005; Shenandoah & George, 1998).

Skywoman was already pregnant when she came to the earth and soon had a daughter. The daughter grew into a woman quickly and was approached by suitors who were actually spiritual powers. Her mother helped her choose among the suitors and finally approved one. This suitor impregnated the daughter through means other than intercourse and she had twins. One of the twins was good and the other was not good. The good twin, Skyholder, was born in the usual way, but the bad twin, Flint, refused to be born in the natural way and forced his way out of his mother's body; killing her in the process. The twins were raised by their grandmother, Skywoman, who mistakenly thought that Skyholder killed his mother and therefore favored Flint. The twins grew quickly and soon Skyholder was on his own. He realized that he had power to create things from the earth and could breath a living spirit into them. He created many kinds of plants and animals, including the birds. He also created natural things such as rivers and mountains. His brother, Flint, could create things too but he was of a bad mind and the things he created never turned out the way he wanted them to. The animals he created turned out to be spiders, bats, and fearsome creatures. He became very jealous of Skyholder's creations and soon set about making negative creations. Skyholder made people last. Before he created them he worked with the animals and other forces, making agreements with them to take care of the humans. He recognized that human beings were to be the most pitiful of all his creations and that they would require much assistance in



order to survive. Eventually, a battle between the twins ensued and Skyholder won but he refused to kill his brother so they made an agreement about letting all that was created remain and to not interfere with it (Elm & Antone, 2000; Mitchell et al., 1994; Mohawk, 2005).

The creation story goes on to explain the origins of the sun, moon and stars as well as the other forces in nature and everything within the OnΛyoteʔa·káʔ worldview. Parts of these teachings describe agreements that Skyholder made with powers that were already part of this planet before Skywoman came here. Some of these powers have agreed to help people with different types of healing. Some of these forces help with physical healing, while others help with psychological healing. All of these healing forces have agreed to continue to help as long as the people remember and acknowledge them through ceremonies. Once the people forget them, they will no longer come to help. The forces have agreed to come to heal when they are called upon. If a person is in need of healing, certain people within the community can recognize which healing spirit is reaching out to that person. There are other people who have worked with that spirit in the past and all of those people will be part of the healing process as well. In this way, healing is done in a group manner. Once the person is healed, he or she becomes part of that group and will have a lifelong commitment to continue making sure that the ceremonies that acknowledge and thank that healing spirit are carried on, and they will be part of healing ceremonies for others that require the healing that group and spirit provides (Elm & Antone, 2000; Mohawk, 2005; Shimony, 1994).

Several themes emerge from the creation story that help to understand the OnΛyoteʔa·káʔ worldview. There appears to be a primacy placed on the women and

warnings about jealousy and favoritism. In addition, there seems to be an acknowledgement that the earth has power to grow and produce creations. Furthermore, the twins convey an impression about there being positive and negative or good and bad in all things. Also, the importance of the animals and spiritual forces gives some insight into the Onayote'a·ká? view of their place within nature and the world. They do not see themselves as at the top of creation; rather, the view is that they must remember to work to be caretakers of the earth and all that it provides.

*Original instructions.* Among the themes that come with the Creation story are original instructions for how to live. For the Onayote'a·ká?, these instructions are straightforward: live in peace and harmony. When Skyholder left he instructed the first people to closely attend to their thinking as well as everyone else's to maintain happiness and a clear thinking to the point of everyone being of one mind. In this way everyone would have peacefulness of mind. In addition, he instructed that everything on the earth had an equal right to what was created, and remembering that would cause everything to live in harmony. This assisted the people to remember their place within the world and encouraged them to find peace and harmony with all of creation. In addition the people were instructed to carry out ceremonies, annually, giving thanks for all that was in creation and provided for looking forward to maintaining the way of life (Mohawk, 2005).

*Clans.* Clan affiliation was developed as a method of organizing increased population at a time not long after people were created. Mohawk (2005) reports that before the clan system was developed, everyone in the community would mourn every death and their responsibilities would become neglected. The people were responsible

for ensuring that the teachings of the creation story were passed on, that ceremonies of thanksgiving and acknowledgement were conducted, that conflicts were resolved, and that everyone understood their roles and responsibilities within the community. The On̓yote'a·ká? have the three clans of wolf, turtle, and bear. Members within a clan maintain relationships similar to siblings while relationships among the clans share familial responsibilities. When there is a death, members of the clan of the deceased mourn while members of the other two clans work to make sure that all community responsibilities are completed. It was said that the non-mourners were clear-minded, with an emphasis on the value of thinking and the possibility of disrupted thinking when something negative occurred. In addition to ensuring the community operates smoothly, the clans worked as an accountability system for political issues, with each clan acting as a check and balance for the others (Mohawk, 2005; Porter, 1993; Shimony, 1994; Tehanetorens, 1998). Furthermore, clan affiliation created a method for relating to other indigenous people across the continent as many of the other First Nations had clan systems as well. In this way, someone of the wolf clan was considered related to all other wolf clan members across all of the First Nations (Ross, 1989).

*Great Law of Peace.* The Haudenosaunee confederacy was originally created from five Nations, which shared common beliefs including their creation story and clan system. These five Nations were the Mohawk, On̓yote'a·ká?, Onondaga, Cayuga, and Seneca. The confederacy was created at a time when these five nations were engaged in warfare with each other much of the time. An historical figure and prophet came and reminded the people that the Creator had not intended for them to be violent. He established a method of creating peace through diplomacy rather than warfare and

violence. Fifty women were chosen as leaders. Those women then chose fifty men to represent their families for political dealings within and outside of the confederacy. All 100 of these female and male leaders agreed to not engage in violence and warfare and instead engage in diplomatic means. The emphasis on peace was, and continues to be, so strong that each of the five Nations were said to bury all of their weapons of war and all agreed to never pick them up again. In this way disputes are resolved and ruling is conducted through diplomatic methods and peace. In reality, The Great Law was a codification of the original instructions and a re-instruction to maintain peace and harmony.

For those who accept the Great Law, the bonds created are so strong that anything done to another is as if it is done to the self. Any angry verbal or physical outburst was replaced with a sense of compassion and assistance. Other First Nations were greatly influenced by this peaceful method and joined the confederacy in principle, and sometimes in body, such as when the Tuscarora joined in the early 1700s (Mohawk, 2005; Wallace, 1994; Dennis, 1993). Adherence by all to The Great Law was not strong enough during times of European contact and especially through the Revolutionary War, to keep the Confederacy from taking different sides. However, it continues to be the effective guiding principles of the confederacy leaders today (Dennis, 1993; Gibson, 1992; Snow, 1996).

*Grief.* Also at the time of the Great Law a prescribed way to manage grief was introduced. This method involves a formal condolence ceremony to occur when a leader dies and is replaced. There are 15 matters that are attended to, with some of the matters specifically for grieving and some for formal replacement of a leader. The matters

specific to grieving include cleaning the eyes, ears, and throat so that the covering of grief can be lifted and the person can again see, hear, and say the good things that are in this world. Also, the grieving process continues with feelings of being covered with darkness, and having lost the sky and sun meaning that the person has become restricted in the way they view and interact with the world. Losing the sky and the sun addresses losing connection with other people, the bright side of life, and a broad perspective because of an over-focus on grief and loss. Much of the sensibilities that need to be recovered have to do with thinking or the mind, and this ceremony seeks to ensure that no ill thinking remains after grieving. It also reminds the people of their bonds with others in the community and world and to regain a sense of compassion and goodness with creation.

It has been suggested by Antone, Miller, and Myers (1986) that the matters specific to grieving can be applied to an individual and that some of those can be used with modern day depression. It is noted that grief leaves behind a feeling of darkness and that if someone is left in this state the energy of the darkness can overcome his or her sensibilities. The condolence ceremony that came at the time of the Great Law emphasized the importance for a person to regain control of their life. If grief is left unresolved it can turn into depression. The Great Law describes the whole person being able to use the Good Mind (Ka'nikuhli·yó). The Good Mind includes considerations of compassion and innocence, caring and connectedness, words of encouragement, empowerment, spirituality and righteousness, peace and justice, humility in service for the people and the Creator. When a person is overcome with grief in an unusually difficult or prolonged time it becomes unresolved. Unresolved grief can turn into

depression. It is at this point that the person needs assistance to get their mind back into order and get their spirit rekindled and strong again (Antone, Miller, & Myers, 1986).

Part of this has to do with accepting the loss and engaging in the world in a positive manner again in order to enjoy life again (Antone, Miller, & Myers, 1986; Dennis, 1993; Shimoney, 1994; Snow, 1996).

*Skʌnʌtali·yó.* Skʌnʌtali·yó, also known as Handsome Lake, was a prophet who received a vision and messages from some of the spirit helpers in approximately the year 1790. This was at a time after the Revolutionary War when the confederacy was split up over breaking the Great Law of Peace when some of the five Nations sided with the British while others sided with the colonists. Devastation was also created from the Native casualties and decimation of crops and villages due to the war, along with an increase in alcohol consumption. Skʌnʌtali·yó was shown a path for reconnecting with the original instructions. His vision included a way to merge original Haudenosaunee beliefs with the changing world including the new United States and Christianity. The message that Skʌnʌtali·yó spread after his vision was followed by many of the Haudenosaunee people, but not all. Some continue to hold to the original teachings based in the creation story and the Great Law and are wary of incorporating foreign beliefs. Nonetheless, since the time of Skʌnʌtali·yó's life and still now, the teachings are recited among Haudenosaunee communities on an annual basis (Parker, 1990; Shimony, 1994). His good message or Kaliwi·yó, is used as a reminder of the intended way to live. It also serves as a reminder to continue to acknowledge relationships with other entities within creation including the spirits that Skyholder made agreements with when he was first making his creations on the earth (Shimony, 1994).

*Relationship to healing spirits.* Skyholder knew that his brother Flint would create things that would interfere with the people's ability to be healthy, happy and fulfill their original instructions. In a fair approximation of translation, he called these creations sickness or disease. To help the people cope with this, Skyholder provided medicine in the form of plants and ritual, and made agreements with spiritual forces that already existed to provide healing for the people. The knowledge of the plants that he imparted was intended to be passed down from generation to generation, as were the instructions for invoking help from the spirits. These instructions continue to be passed from generation to generation today (Elm & Antone, 2000; Mohawk, 2005; Shimony, 1994; Wallace, 1994).

*Traditional spiritual healing system.* Mohawk (2005) relates how Skyholder made an agreement with Hatuwi, also known as False Face. Skyholder recognized that Hatuwi was not one of his creations and that he had the power to heal. Hatuwi recognized that the people would need his help with some of the sicknesses that they would encounter so he agreed to be of assistance and alleviate physical and psychological suffering as long as the people called on him. Hatuwi is called upon to alleviate a wide variety of suffering. There are other spiritual forces that are called upon as well, and those that enter into a relationship with these healing spirits become part of a group that then is responsible for helping others who need that spirit for healing. Little is written about any of these spiritual medicines, with Hatuwi being written about the most. It seems to be recognized by the Haudenosaunee people that the healing spirits are meant to be there in time of suffering and to be held in an extremely revered manner (Mohawk, 2005; Shimony, 1994; Snow, 1996). Lefley (1999) notes that even in modern times,

more culturally traditional people frequently bring their problems to a traditional healer to be cured within that meaning-making system before seeking a EuroAmerican health professional.

*Community leaders.* The On̓ayoteʔa·káʔ and Haudenosaunee communities had female and male leaders. The female leaders were called Kutíyanéshu (Clan Mothers), while the male leaders were called Lotíyanéshu (Chiefs), with the On̓ayoteʔa·káʔ terms indicating a long path and an acknowledgement that their roles were intertwined with spiritual and political responsibilities. In addition, other people in the community were charged with making sure that the ceremonies, history, language, and traditional ways of life were maintained. These people were called Kayé Niyolí·wake Lonatlihu·tú (Faithkeepers) (Shimony, 1994; Porter, 1993).

The Kutíyanéshu lead the longhouse and were responsible for managing the people. They did this by ascertaining the peoples' views and concerns, from the youngest to the eldest. In addition, they reminded each person of their roles and responsibilities within the community and within creation. Their main concern was with maintaining family peace and harmony (Shimony, 1994). The Lotíyanéshu duties were as political and spiritual leaders. They took direction from the Kutíyanéshu about the concerns and wishes of the community. The Lotíyanéshu then integrated these with political and spiritual concerns. They also worked to settle disputes being concerned with maintaining community peace and harmony (Shimony, 1994). Kayé Niyolí·wake Lonatlihu·tú were charged with carrying on all the traditions. This included mentoring others to maintain traditional knowledge, language, ceremonies and customs. They ensured that the ceremonies were continued to be carried out as they were intended. The Kayé



Niyolí·wake Lonatlihu·tú were also sought out for information and advice about roles and responsibilities, dispute resolution, and healing (Shimony, 1994).

*Community life.* An historical Onʼayoteʼa·káʼ community life has been presented above with attention paid to a neighborly manner. This close-knit picture presents opportunities for people to practice encouraging and empowering each other, maintaining personal and community responsibilities, and having a shared sense of connectedness with family and the larger community. Also in this setting there is a connectedness with a cycle of spirituality and shared intimacy with all of creation. Historically, the Onʼayoteʼa·káʼ communities would have had all of this along with naturally sharing all that one had to help others. The context for this lifestyle comes from foundational Onʼayoteʼa·káʼ stories. The creation story teaches about positive and negative in all things and finding balance. The personal thanksgiving teaches gratitude for all things, and the Great Law teaches compassion. Modern times find that some people hold to the original ways of living and relating with others and creation, while other people have become more self-centered and tend to not be personally in touch with the teachings of the old stories. In this way the ones that do live as intended stand out as examples of living in a positive manner, whereas in the old days they would have been like everyone else (Antone, Miller, & Myers, 1986; Dennis, 1993; Elm & Antone, 2000; Mohawk, 2005; Snow, 1996; Wallace, 1994).

## CHAPTER 2.

### Literature Review

Native American Indians consistently occupy the worst rung in many physical and mental health problem indices from the highest rates of coronary heart problems, obesity and diabetes to high rates of suicide and mental health diagnoses (Beals, Novins, Whitesell, Spicer, Mitchell & Manson, 2005; Beals, Manson, Whitesell, Spicer, Novins & Mitchell, 2005; National Institute of Mental Health, 1987; U. S. Commission on Civil Rights, 2004; Wisconsin Department of Health and Family Services, 2004). The models of treatment and prevention being utilized are insufficient given that meaningful cross-cultural research addressing the theoretical and practical needs for this population is scant at best (APA, 2000; Duran & Duran, 1995; Kleinman & Good, 1985; Manson, Shore, & Bloom, 1985; O'Neill, 1989). It appears that either the psychological profession does not feel the need to address the culturally specific meaning for this population because Native American Indians only make up approximately 1.5% of the U.S. population, or there has yet to be researchers who feel able to address the area of determining whether Western diagnostic labels, which determine health data, hold heuristic value with other cultures (Good, 1992, 1993, 1994; Jaimes, 1992; Kleinman, 1988; Levers, 2006; Manson, Shore, & Bloom, 1985; Marks, 2006; Nabokov, 1999; O'Neill, 1989; Struthers, Lauderdale, Nichols, Tom-Orme, & Strickland, 2005; U.S. Census Bureau, 2006).

One vexing matter is that the mental health diagnoses are based on the current version of the DSM, even though it is not known if the constructs represented hold the same meaning within Native American Indian populations. The cross-cultural literature

tends to reflect research methods that rest upon a mainstream and Western cultural lens giving little value to other cultures' worldviews and how these might alter conclusions drawn (Hahn, 1995; Kleinman, 1988; Manson, 2005; Manson, Shore & Bloom, 1985; O'Neill, 1998, 2004; Struthers, Lauderdale, Nichols, Tom-Orme & Strickland, 2005; U. S. Commission on Civil Rights, 2004).

This literature review includes (1) an examination of major depression, including among Native American Indians and the Onʼlayoteʼa·káʼ specifically, (2) concepts of worldviews and their application to mental health, (3) a review of pan-Native-centric views of mental health as a framework for understanding the traditional Onʼlayoteʼa·káʼ beliefs, (4) summaries and critiques of relevant previous studies involving Native American Indian communities, (5) a response to the call from the field, and (6) an exploration of an appropriate method of study.

### *Major Depression*

Depression has been defined and described in different ways whether it be by laypeople or psychological professionals, from everyday moments of sadness to much more severe experiences. The DSM-IV-TR (APA, 2000) was created to assist professionals to diagnose and differentiate psychological problems. Currently this manual is in its fourth revision and includes a mood disorders section, which “includes disorder that have a disturbance in mood as the predominant feature” (p. 345). This section provides criteria for diagnosing different types of depression. The types of depression are differentiated along the lines of time-course (e.g., Dysthymia), cycling patterns (e.g., Cyclothymia), associated features (i.e., psychotic, catatonic, melancholic,

atypical, or postpartum), as well as severity of the problem (e.g., Bipolar I vs. Bipolar II). However, the basic criteria for depressed mood carry throughout the different disorders.

For this study, Major Depressive Disorder was chosen as the focus. The DSM-IV-TR criteria for Major Depressive Disorder (MDD) begin with one or more Major Depressive Episodes that are not better accounted for by another disorder or caused by a medical condition or substance use. In addition, the diagnosis includes specifiers for severity, and single episode, recurrent, or state of remission if applicable (APA, 2000). The criteria for MDD generally fall into four categories: (1) affective, as in feeling sad, (2) behavioral, with psychomotor changes and not engaging in previously enjoyable activities, (3) cognitive, with thoughts of death and worthlessness, as well as concentration and decision-making problems, and (4) somatic, including appetite and sleep changes (Manson, Shore, & Bloom, 1985). Full diagnostic criteria can be found in appendix D.

### *Etiology*

The DSM-IV-TR (APA, 2000) does not provide an explanation for the causes of psychological disorders, such as depression. However, it seems clear that professionals with a psychopharmacological orientation believe the cause of depression is an imbalance of chemistry within the brain (Bolling & Kohlenberg, 2004; Casacalenda, Perry, & Looper, 2002; Elkin, et al., 1989; Fava & Davidson, 1996; Gotlib & Hammen, 2002; Hirschfeld et al., 2000; Thase, Fava, Zimmerman & Culpepper, 2006). While those with a more cognitive or cognitive-behavioral approach believe that maladaptive thoughts and behaviors are the cause (Beck, 1963; Beck, Rush, Shaw, & Emery, 1979; Coyne, 1976; Dobson, 2001; Skinner, 1953). Furthermore, those with an interpersonal approach

believe that the four subjects of grief, interpersonal role disputes, role transitions, and interpersonal deficits are potential problem areas that may lead to depressive symptoms (Gruenberg & Goldstein, 1997; Klerman, Weissman, Rounsaville & Chevron, 1994; LaFarge & Zimmer, 1997; Sullivan, 1953).

The anthropologist Lefley (1999) suggested that disorders “are based on etiological concepts that typically involve some imbalance in life forces” (p. 579), which appears to be consistent with all three positions stated above. Further, he suggested that treatment involves correcting the imbalance through appropriate means as culturally defined (Lefley, 1999). Importantly, it has been noted that many EuroAmerican healers look to psychodynamic or behavioral cures, and pharmacologic interventions, while some non-EuroAmerican healers attempt a more holistic approach and include spiritual causes and treatments (Good, 1992, 1993; Lefley, 1999). Lefley’s ideas about how worldviews affect understanding of symptomatology will be discussed further below.

### *General Prevalence*

The prevalence of broadly defined adult depression has been fairly stable over 15 years in the United States with reports of 10-11% of the population suffering from the disorder, which accounted for approximately 18 million adults in the year 2000 (Greenberg, Kessler, Birnbaum, Leong, Lowe, Berglund, & Corey-Lisle, 2003; Gotlib and Hammen, 2002; Hirschfeld et al., 2000). It has been reported that the rate of broadly defined depression is 22% in primary care settings and the lifetime rate of being afflicted with depression is 17% with 20-25% of those women and 7-12% being men (Coyne, Fechner-Bates, and Schwenk, 1994; Culpepper, 2006; Gotlib and Hammen, 2002; U.S. Department of Health and Human Services, 1999a).

### *Costs Associated with Depression*

Depression is a very costly mental health problem. These costs include economic, social, and family areas and are determined by its prevalence rate, rate of treatment, and level of debilitation (Greenberg et al., 2003). Depression is known to affect multiple areas of functioning and is implicated in limiting activities at home, work, or school, reducing educational attainment, marital instability, increasing the likelihood of unplanned pregnancy, and mortality (Greenberg et al., 2003; Greenberg, Stiglin, Findelstein, & Berndt, 1993; Hirschfeld et al., 2000; Simon, 2003; State of Wisconsin, 2000; U.S. Department of Health and Human Services, 1999a; Wang & Kessler, 2006). Furthermore, it is suspected that exactly how widespread the effects of depression are is not completely known and therefore the costs may be even greater than any current estimate (Greenberg, et al., 1993; Simon, 2003). Simon (2003) suggests that the effects of depression extend to arenas of work productivity and increased use of health services creating an impact on employers and family members. Lower social functioning and quality of life, including health status, disability, and level of impairment (Hirschfeld et al., 2000) further add to the impact of depression, with both of these being implicated in creating a downward spiral that further exacerbates the symptoms contributing to the chronic, recurrent nature of depression and leading to longer-term effects including increasing the risk for family members and caregivers becoming depressed (Hirschfeld et al., 2000; Wang & Kessler, 2006).

*Categories of cost.* The three categories of (1) direct treatment costs, (2) indirect economic costs arising from increased mortality rates, and (3) indirect economic burdens arising from productivity are typically used to report the cost of depression. Direct

treatment costs consist of money spent for treatment, including in- and outpatient, and pharmacological. Indirect economic costs due to an increase in mortality are measured by suicides, and indirect economic burdens due to workplace productivity are measured both in terms of absenteeism and presenteeism (Greenberg et al., 2003; Greenberg et al., 1993; Wang & Kessler, 2006). Greenberg et al. (2003) reported that the cost of depression was approximately \$83 billion in the year 2000.

*Direct treatment costs.* Greenberg et al. (2003) discovered a shift in treatment costs from 1990 compared to 2000. They reported an increase in the number of individuals receiving treatment and a change from more expensive inpatient to less costly outpatient settings and pharmacological management. Even though they found a 50% increase in treatment utilization, this shift to less costly forms of treatment decreased the annual direct cost per treated patient from around \$4100 in 1990 to \$3300 in the year 2000. The authors reported direct treatment costs of \$26.1 billion.

*Costs due to suicide.* Greenberg et al. (2003) reported that \$5.4 billion was accounted for by suicide-related mortality costs. The economic costs arising from suicides have not been reported in a manner that allows the total cost to be broken down. However, it has been acknowledged that the impacts of suicide attempts and completed suicides are far reaching, affecting co-workers, friends, and family members as well as involving medical and mental health professionals (Hirschfeld, 2000; Simon, 2003; Wang & Kessler, 2006).

*Productivity costs.* Workplace costs account for the largest measured cost of the effects of depression, with Greenberg et al. (2003) reporting \$51.5 billion in lost workplace productivity. These costs are separated into absenteeism, including

unemployment and time missed from work, and presenteeism, or decreased productivity or injury even though the individual was physically present at work (Greenberg, 1993; Simon, 2003). Ormel, VonKorff, Ustan, Pini, Korten, and Oldehinkel (1994) and Kessler, Barber, Birnbaum, Frank, Greenberg, Rose, Simon, and Wang (1999) reported that depressive disorder was associated with a two to two-and-a-half increase in days missed compared with non-depressed individuals and a 50% increase in time lost from work. Stewart, Ricci, Chee, Hahn, and Morganstein (2003) indicated that only 19% of lost productivity costs were due to absenteeism, while 81% of the costs were attributed to presenteeism.

Some interesting observations have been made hinting at the scope and breath of the effects of depression. First, it was noted that a lower unemployment rate, which translates to a larger workforce, likely indicates that more depressed people were employed in the year 2000 than in 1990 (Greenberg et al., 2003). In addition, with the shift away from inpatient treatment to pharmacological management, which can be prescribed by general practitioners, has changed the primary impact of depression to the use of general medical services, rather than on resources directed to depression treatment resulting in a “1.5 to 2-fold increase in use of general medical services associated with depression” (Simon, 2003, p. 212). Finally, comorbidity with other psychological disorders and/or medical conditions seems to increase the burden by further decreasing quality of life and social interactions, and increasing use of general medical services (Greenberg et al., 1993; Simon, 2003).



*Prevalence Among Native American Indians Within the State of Wisconsin*

It has been found that Native American Indians have one of the highest rates of psychiatric admissions in the United States and are considered to be at a higher risk for mental health disorders than other ethnic groups (U. S. Commission on Civil Rights, 2004). This is at least partly due to being consistently overrepresented among populations found to be at high-need for mental health services (Nelson, McCoy, Stetter, & Vanderwagen, 1992; U. S. Commission on Civil Rights, 2004).

Reasons that indicate high need include being homeless or incarcerated, abusing substances, being victims of stress and trauma associated with long-term discrimination, imposed loss of culture, and assimilative and acculturative forces including, pervasive poverty, hopelessness, intergenerational trauma, and the negative relationship with the federal government (Koegel, Brunam & Farr, 1988; Lefley, 1999; Manson, 1995; Manson & Kleinman, 1998; National Institute of Mental Health, 1987; Shore & Manson, 1981; U. S. Commission on Civil Rights, 2004; Wilson, Civic & Glass, 1995). Native American Indians are overrepresented among these areas (Nelson, McCoy, Stetter, & Vanderwagen, 1992).

In a review of studies, Manson, Shore, and Bloom (1985) found that depression was the most frequently diagnosed mental disorder among Native American Indians at mental health facilities and accounted for approximately 40% of the daily case load (American Indian Health Care Association, 1978; Rhoades, Marshgall, Attneave, Echohawk, Bjork, & Beiser, 1980; Sue, 1977). The U.S. Commission on Civil Rights (2004) more recent findings agreed that depression continues to be a dominant concern for Native American Indians.

Studies that specifically focus on the state of Wisconsin indicate that the depression-related hospitalization rate for Native American Indians is almost twice (1.8) that of the state's general population (Wisconsin Department of Health and Family Services, 2004). In addition, the State of Wisconsin (2000) acknowledged that ethnic minorities are underserved in the mental health care system, and that there is a need to adapt treatment to include variables such as culture. It has been estimated that approximately 700 Native American Indian individuals, mostly Oneida, are consistently seen each month at the Oneida Behavioral Health Clinic with depression being one of the most frequent diagnoses along with co-occurring illnesses including substance abuse, medical conditions, and various psychological diagnoses. This information has remained relatively stable during the duration of the current study (K. Ninham, personal communications, December 9, 2008; January 22, 2007).

In summary, diagnoses of major depressive disorder is a serious and prevalent problem among Native American Indians. However, it has yet to be determined whether the Western-based DSM diagnosis holds the same meaning for Native American Indians who hold a traditional worldview. This study focuses on whether symptoms that would be diagnosed as MDD in the Western-based DSM system are conceptualized in a similar manner with traditional Native American Indians in one specific Nation. At this point a brief discussion of mental disorders and diagnosis in the context of culture is important.

### *Worldviews*

The U.S. Department of Health and Human Services (1999a) defines culture as “a common heritage or set of beliefs, norms, and values” that “refers to the shared, and largely learned, attributes of a group of people” and note that “anthropologists often

describe culture as a system of shared meanings” (p. 15). The U.S. Department of Health and Human Services (1999a) also points out that the term culture applies to all people, including European Americans. Acknowledged in this definition is the fact that culture provides meaning for the experience of mental health and psychological disorders (U.S. Department of Health and Human Services, 1999b, 2001). Gruenberg and Goldstein (1997) and Kleinman (1988) indicate that the languages used by different ethnic groups to express depressive symptoms vary and that it is important to understand the specific expression and meaning that is being conveyed.

### *Worldview Defined*

Sue, Ivey, and Pedersen (1996) note that cultural differences can be expressed through one’s “worldview” (p. 137). Sue (1978) defined a worldview as the way an individual understands their relationship to their world, including nature, other people and institutions. Sue and Sue (2003) continue to rely on previous definitions of worldview and succinctly state that worldviews are “composed of our attitudes, values, opinions, and concepts” and also “affect how we think, define events, make decisions, and behave” (p. 268). Ibrahim (1984, 1985) is often credited with bringing the concept of worldview into modern times. His work emerged from Kluckhohn’s (1951, 1956) cross-cultural work on value orientations and emphasis. The Kluckhohn framework considered the dimensions of individual and group values, beliefs, attitudes, assumptions and behaviors and postulated that these influence motivations, decisions, behaviors and life-styles. Kluckhohn and Strodtbeck (1961) recognized that cultural groups’ worldviews differed in how they understand time (here and now vs. history and tradition), attitudes about activity (doing vs. becoming), importance of relationships with others (hierarchical

vs. collateral), the nature of people (good vs. bad), and the relationship to the natural world (harmony vs. dominance over or exploitation). A worldview provides a conceptual framework for making meaning (Simek-Downing, 1989) and is correlated with cultural upbringing (Ibrahim, 1985; Ivey, Ivey, & Simek-Downing, 1987; Katz, 1985; Sue, 1978; Sue & Sue, 1999).

*Culture and Worldview Applied to Mental Health and Illness*

Many EuroAmerican mental health professionals are trained within a culture that makes meaning based on a Cartesian philosophy and knowledge acquired solely through scientific, objective and empirical methods (Hahn, 1995; Kleinman, 1988). In this way they share a worldview about the inter-relationship between mind, body and environment and their impacts on the presentation and interpretation of symptoms and behavior. This worldview, or perspective, may differ from their client's at times (U.S. Department of Health and Human Services 1999b). Even within a EuroAmerican framework, psychological disorders can be viewed as having different causes and treatments depending on how their meaning is determined. For example, a neuropsychologist may understand depression as a change in electrophysiological activity or other brain structure functioning, whereas a pharmacologist may view depression as a change in neurochemical activity, and a psychologist may see it as changes in behavioral, cognitive, affective and somatic areas (Klerman, Weissman, Rounsaville, & Chevron, 1994; Vanthuyne, 2003).

Lefley (1999) agrees with including the concept of worldview in the definition of culture and applies that to understanding behaviors within their cultural context. He also advocates for using the worldview as a basis for determining whether certain behaviors

are considered disorders, and if they are, looking to the culture for explanations of causes and healing. Likewise, it is recognized that what constitutes mental well-being is derived from social comparison based on cultural norms and expectations (Lefley, 1999; Manson, 1995; Scadding 1996, 1990; U. S. Department of Health and Human Services, 2001). Becker and Kleinman (1991) relate that not all cultures view depression the same way as a EuroAmerican society. In addition, definitions and criteria are based on meaning systems that are determined by local society, and these different meanings determine the expression and experience of a disorder.

In short, it is the local culture, using its own idioms, that determines what falls within expectations and what does not (Horowitz, 1982). Each culture has its own manner to make meaning of the world and experiences. It is these cultural meanings and interpretations that determine whether thoughts, feelings, behaviors, and/or physical sensations are within or outside of usual expectations of individuals of a shared culture. In addition, each culture uses its own idioms, or heuristic terms, to express meaning for symptoms and diagnostic labels.

#### *Local Cultural Idioms of Distress*

The language and phrases used in distinct cultural groups to convey psychological distress may not readily translate the meaning in a manner that is congruent with other cultures (APA, 2000; U.S. Department of Health and Human Services, 2001). A number of researchers and clinicians agree that an understanding of the experiences of people from cultures other than their own must be situated within the framework of the other culture's meaning making system (Andreasen, 1997; Ciompi, 1984; Foucault, 1988; Good, 1994; Strauss, 1989; Vanthuyne, 2003). The experience of distress, for example,

has meaning attached to it by systems within societies and it is these systems that provide the framework for expressing and understanding the meaning of what is being conveyed (Estroff, 1981; Fabrega, 2001; Kleinman, 1980; Leslie, 1980; Ornstein & Swencionis, 1990; Vanthuyne, 2003). This understanding and articulation, which is standardized within a culture, is referred to as a cultural idiom.

Cultural idioms are composed of a “system of values, patterns of association, vectors of interpretation, and epistemological horizons” (p. 10) that provide structure for the way an individual experiences, makes meaning of, and reacts to their experiences (Crapanzano & Garrison, 1977). This approach assists individuals, who are distressed due to experiences that are not natural, to provide meaning within their familiar culture to what is occurring so that they can make some sense of the experience (Vanthuyne, 2003). Local idioms must be understood in order to understand what someone from a different culture is experiencing and expressing, as well as how that experience is being interpreted by those helping him or her.

In summary, from the perspective of different worldviews and local idioms of distress, it might be doubted that a Western conceptualization of mental illness would apply to other cultures. However, Western-based diagnostic criteria and mental illness conceptualization are currently what much of the research literature is based upon. This study will explore the extent that Western concepts translate for traditional people from one specific Nation.

#### *Pan-Native-Centric Theory*

Many mental health researchers have called for specific work with Native American Indian populations and the DSM-IV-TR calls for informed research as it

develops new editions (APA, 2000; O'Neill, 1989). The following review of Pan-Native-centric theory on mental health provides an explanation of the existing theoretical orientation of this literature. The conceptual work of Eduardo Duran (1990) about pan-Native views of mental health that has become a primary source for studies in the area of Native American Indian mental health is reviewed, and an examination of emerging and Native-centric studies is presented.

There are several names that commonly come to mind when one discussed Native American mental health. Among those are Eduardo Duran, Marie Yell-Horse Brave Heart and Teresa LaFromboise. A search of PsycINFO covering the years 1987 to the present revealed forty references with her name. However, three of those references covered her Zuni Life Skills Development program and curriculum, which is a suicide prevention intervention, (LaFromboise & Hayes, 2008; LaFromboise & Howard-Pitney, 1994, 1995) and one covered a more general American Indian life skills development curriculum (LaFromboise, 1996). Five others dealt with suicide specifically (Howard-Pitney, LaFromboise, Basil, September, & Johnson, 1992; LaFromboise & Bigfoot, 1988; LaFromboise, Howard-Pitney, & Canetto, 1995; LaFromboise, Medoff, Lee, & Harris, 2007; Yoder, Whitbeck, Hoyt, & LaFromboise, 2006). Ten focused on women or youth exclusively (Bee-Gates, Howard-Pitney, LaFromboise, & Rowe, 1996; Bigfoot-Sipes, Dauphinais, LaFromboise, Bennett, & Rowe, 1992; Hill, Soriano, Chen, LaFromboise, & Eron, 1994; LaFromboise, Berman, & Sohi, 1994; LaFromboise, Choney, James, Wolf, & Landrine, 1995; LaFromboise, Dizon, Gibbs, & Taylor, 2003; LaFromboise, Heyle, Ozer, Peplau, DeBro, & Chapman, 1999; LaFromboise, Hoyt, Oliver, & Whitbeck, 2006;

LaFromboise, Low, Graff, Gibbs, & Huang, 1989; LaFromboise, Low, Graff, Gibbs, & Huang, 1998).

One of LaFromboise's papers concentrated on sex roles (LaFromboise, Heyle, & Ozer, 1990). Two of her references were on ethics in multicultural counseling (LaFromboise & Foster, 1989; LaFromboise, Foster, & James, 1996). Four of the references focused on identity in general (Bryant & LaFromboise, 2005; LaFromboise, Coleman, & Gerton, 1993, 1995; Sue, Carter, Casas, Fouad, Ivey, Jensen, LaFromboise, Manese, Ponterotto, & Vazquez-Nutall, 1998), while three concentrated on general multicultural competence and/or counseling (LaFromboise, Coleman, Hardin, & Hernandez, 1991; LaFromboise & Foster, 1992; Miranda, Bernal, Lau, Kohn, Hwang, & LaFromboise, 2005). LaFromboise (2001) provides a personal account of her transformation from undergraduate student into professional psychology professor. And, one was an obituary (LaFromboise & Trimble, 1996).

The same LaFromboise (1988) piece on American Indian mental health policy was listed twice in the PsycINFO search. She also updated this piece in 1998 for inclusion in Atkinson, Morten, and Sue's (1998) text, Counseling American Minorities. This work provided an overview of general Native American Indian demographics, psychological services available, utilization, and delivery, and several recommendations for recruiting, educating and training Native American Indian students, and for increasing political-organizational involvement of Native American Indians. LaFromboise's works for the texts, Handbook of Cross-Cultural Counseling and Therapy (Pederson, 1987), Counseling American Minorities: A Cross-Cultural Perspective, Fourth Edition, (Atkinson, Morten,



& Sue, 1993), and Counseling American Minorities, Fifth Edition (Atkinson, Morten, & Sue, 1998) similarly provide good general information about Native American Indians.

Teresa LaFromboise's personal webpage at Stanford University (<http://www.stanford.edu/group/adolescent.ctr/Research/lafromboise.html>) indicates that she is "concerned about stress-related problems of ethnic minority youth," and that "her research topics include: interpersonal influence in multicultural counseling; bicultural competence; and ethnic identity and adolescent health." "Dr. LaFromboise is currently investigating parental drinking, parenting, and alcohol use among American Indian adolescents. She teaches seminars on Counseling Theories and interventions from a Multicultural Perspective, Education and American Indian Mental Health, and Racial and Ethnic Identity Development."

Teresa LaFromboise's listed focus of work appears to be on multicultural counseling in general and on ethnic identity and youth. Much of the information that LaFromboise's publications contribute to the current project comes in the form of reviews of other's works that assists with strengthening previously made points about Native American Indian demographics and poor health indicators in general. Her works focusing on curriculum, suicide, women, youth, sex roles, identity, multicultural competence, along with her personal story are important and provide insights into those specific areas. Those works also restate some general information about Native American Indians. In addition, her contributions to cross-cultural counseling textbooks provide good reviews and recommendations about Native American Indians in general.

LaFromboise (1992) did investigate counseling responses specifically with Native American Indian participants. She used 43 undergraduate Native American Indian

students to act as clients and then judged different types of counselor verbal interventions. Results indicated that counselor who provided verbal interventions in a friendly submissive manner were rated higher than those who provided uncomplimentary interventions that were intended to be helpful. It was also suggested that interventions that were intended to be helpful may have been perceived as hostile or dominant and caused the judges to feel less empowered. These findings may be more meaningful if actual Native American Indian clients had also been asked to be judges.

LaFromboise's (1990) paper titled, "Counseling Intervention and American Indian tradition: An Integrative Approach, which matches the title of her chapter she provided for Counseling American Minorities, Fifth Edition (Atkinson, Morten, & Sue, 1998) discussed training Native American Indian counseling. She also reviewed some previous studies and provided recommendations for psychological interventions. Some of the findings included that traditional Native healing involved more of the larger community, compared to the focus on the client-therapist relationship in Western-based counseling. This engagement in the larger community also results in immersion in a traditional worldview that transforms the experience of symptoms "into elements of social categories rather than being a personal state of mental health" and "new solutions to problems or new ways to see old problems become possible through interconnectedness, creativity, and wisdom within the ceremonial life of the community" (p. 631). LaFromboise added to findings from an older piece (LaFromboise, Dauphinais, & Rowe, 1980) where it was found that trust and flexibility appeared to be the most important counselor characteristics determined by a number of Oklahoma Native American Indian students. LaFromboise (1990) discussed problems that those who

counsel from the Western system have with developing trust with Native American Indian clients in more depth. She indicated that the lack of trust is likely based in the general mistrust established between EuroAmerican and Native American Indians since the time of contact. LaFromboise added the importance of “an understanding of the client’s [specific] cultural values” to establishing trustworthiness as qualities of an effective therapist (p. 635).

LaFromboise (Whitbeck, McMorris, Hoyt, Stubben, & LaFromboise, 2002) also worked on a piece investigating the impact of perceived discrimination and the buffering effects of engagement in traditional practices regarding depressive symptoms with one Native American Indian Nation. The authors noted that the rate of significant depressive symptoms were found to be at a rate several times higher for members of that Nation when compared to the U.S. population in general. In addition, they stated “Depressive symptoms are an important mental health problem for many American Indian communities and warrant serious and urgent attention” (p. 412). The authors also noted that research involving Native American Indians experiences with mental illness is at an early phase and is an understudied area. The authors called for the study of depressive symptoms among Native American Indians to be conducted “Nation by Nation” (p. 412). The findings included experiences with discrimination were strongly associated with depressive symptoms and that engagement with traditional practices was negatively related to symptoms of depression. This indicated that regular engagement in traditional practices such as speaking the language and participating in traditional activities may act to buffer the negative effects of discrimination. It was suggested that the buffering effects of participation in traditional activities might be due to construction

and maintenance of cultural pride and identity based on specific cultural strengths and competencies. The authors noted that their model omitted inclusion of considerations the likely negative effects of historical grief such as those presented by Eduardo Duran and Maria Yellow Horse Brave Heart.

In summary, Teresa LaFromboise's body of work is informative and important. It is largely focused on issues of general cultural competency and counseling. Some of her work has been conducted specifically with Native American Indians. Of this work, some focused on women and youth with a special interest in stress-related problems and cultural identity. Her reviews are especially useful with background information on Native American Indians in general. LaFromboise's 1990 and 2002 works focus on counseling with Native American Indians. In addition to some great insights about how traditional Native healing practices proceed, those authors acknowledge the urgent need for more work to better understand depressive symptomatology among Native American Indians on a Nation-by-Nation basis. LaFromboise's body of work, however, does not largely pertain to a study of traditional Oneida healer's conceptualization of depressive symptoms. Her 2002 work, while neglecting concepts of soul wound and historical grief, may be important to include in a discussion of Native-centric studies of depressive symptoms.

### *Soul Wound*

Eduardo Duran (1990) discussed the ongoing and cumulative effects of negative experiences that perpetrated on Native American Indians. He used the term soul wound to refer to these negative effects. Duran identified that the psychological impacts of the soul wound existed since large-scale contact with Europeans began.

According to his books, Eduardo Duran (Duran, 2006; Duran and Duran, 1995) is of Pueblo and Apache descent. He asserts that his concepts about Native American Indian mental health come from his personal experience in his transformation as a Native professional and from his years of work providing psychological services to Native American Indians in central California. Duran (1995) uses “dreams, Sandtray, cultural and personal metaphor, and non-directive technique...” while finding a “middle ground for effective clinical intervention” (p. xi). Duran often refers to Carl Jung’s theory as integral to his conceptualization including the collective unconscious. Duran (2006) acknowledges that there are fundamental differences in “language, religion, and other aspects of culture that need to be considered when working with Native people...” including “...metaphors of healing.” However, he prefers to discount those differences in favor of his belief in the collective unconscious and “the theory that all human beings are connected at a collective level of psyche” (p. 6-7). This preference and belief allows Duran to treat those who seek his services with healing methods from distinct First Nations along with Western techniques.

Duran's work was the first major attempt to describe pan-Native experiences by intertwining traditional Native American Indian views and Western-based psychology. His concept of soul wound is based on the cumulative and ongoing effects of oppression and trauma that resulted since contact with Europeans. An example of some of these events is presented.

Jaimes (1992) provides an historical account of key U.S. laws, ordinances, acts of congress and case histories as they pertain to Native American Indians. The history of U.S. government policy towards Native American Indians began when alliances were

being created prior to the revolutionary war. The first recorded act from congress was the Northwest Ordinance of 1789. This act was written to end the doctrine of rights of conquest, which had existed up to this point, as held over from European law indicating that the First Nations needed to be dealt with in a fair manner and the land they occupied could not simply be taken by force. The Trade and Intercourse Acts (1790-1834) were passed so that congress could oversee agreements that were being conducted by individual states with First Nations. This act was in response to the fallout from numerous less than upright deals that resulted in First Nation's people losing vast amount of land. The Oneidas once occupied close to six million acres of land prior to European contact. This was reduced to 250,000 acres through negotiations and treaties with the U.S. government in the late 1700s. Prior to the Trade and Intercourse Acts, the state of New York made deals that reduced these land holdings to thirty-two acres. All of these deals were made with individuals who had no authority to speak for the Oneida Nation, and at times were made with individuals from other First Nations entirely (McLester, Torres, Viola, & Jeffery, 2000).

The Indian Removal Act of 1830 was passed with the intention of moving all First Nations' people west of the Mississippi river. The later part of the 1800s and early 1900s was the Boarding School era. The U.S. government provided boarding schools for First Nation's children. These schools were often far from the reservation and the children were usually taken between the ages of five and seven and returned in their later teens. The schools were largely seen as a means of forced assimilation where U.S.-style dress and haircuts were worn, Christianity was practiced by all, and English was the only language allowed. Smith (2005) notes that abuses, including physical, sexual and

emotional, were rampant. Furthermore, Smith (2005) stated that, “Children were given inadequate food and medical care, and were overcrowded in these schools. As a result, they routinely died from starvation and disease” (p. 38). Duran and Duran (1995) noted that the boarding schools were one of the most devastating practices for Native American Indian people.

Through the Major Crimes Act of 1885, Congress gave the U.S. government authority and jurisdiction over certain crimes committed on First Nation’s lands. This undermined sovereignty and the ability to govern for First Nation’s people. The General Allotment Act of 1887 parceled off lands held in common on reservations. The parcels were distributed to those Nations’ individuals and families who resided within the reservation boundaries. However, acreage allotted was usually not contiguous. For the first time Native people had individual ownership of land. The land that was not allotted to the Nation’s people was sold at auction to non-Native people. All owners of these lands, including Natives, were required to pay taxes. Many Native people lost the lands allotted to them for failure to pay taxes.

The Indian Reorganization Act of 1946 required the creation of an elected governmental body for the U.S. federal government to have relations and negotiations with. This served to undermine historical and traditional forms of self-government. The Termination Act of 1953 was an attempt by the U.S. government to reduce its treaty-held financial obligation to First Nations’ people by terminating the recognition of some of the First Nation’s status. The Relocation Act of 1956 provided a U.S. government program to assist First Nation’s people to move from their reservation to urban areas. The act provided for job training centers. However, the program was under-funded and many

First Nation's people found themselves in urban areas far from their reservations with no job or skills and no housing. The Indian Child Welfare Act (ICWA) of 1978 was an attempt by the U.S. government to stop First Nation children from being removed from their families and communities. This act was in reaction to determining that 25% of First Nation children were in placements with non-Natives (Smith, 2005). The American Indian Religious Freedom Act (1978) allowed First Nation's people to practice most of their traditional ceremonial customs, many of which had been criminalized prior to 1900.

The above acts of the U.S. towards First Nation's people have served to undermine self-governance and any positive identity with Native culture. Another result is that many First Nation's people live far from their original homelands. This is due to the removal in 1830, Relocation in 1956, and the placing of Native children in non-Native placements. In addition, the boarding school era was very successful in stripping Native languages and traditional customs from First Nation's people. Collectively, these acts have resulted in many First Nation's people being disconnected from their traditional cultures and original instructions.

Collectively, Duran (1990) discussed the hugely detrimental effects contact had for Native American Indians.

*“The western masculine cosmology literally raped the new world. The rape occurred at all levels of the Indian experience. Rape was done to the earth as well as to the people who were in close harmony with the earth spirits. The western way of being in the world has been systematically forced on Indian people in such brutal and genocidal proportions that there has been a wound severing the connectedness with the earth” (p. 60).*

He also explained that Native people in pre-contact times lived within a balanced existence while remaining intertwined and inseparable from the rest of creation. This was contrasted with the continuing and horrific effects of colonization including pressures of assimilation and acculturation. These colonization effects have resulted in



tearing the people from their balanced existence into one that has deeply and negatively affected their psyche. The results of this deep psychological insult include identity problems, disharmony in relationships, substance abuse, and being cutoff from historical and traditional worldviews and means of healing (Arndt, 2005). Duran and Duran (1995) indicate that the disruptions caused by the soul wound reach beyond the individual and negatively affect Native American Indian spirituality, existence and their collective psyche.

Duran (1990) acknowledges that different Nations experience European contact at different times in history and under varying circumstances. He further recognizes that some Nation's experiences were more negative than others and that all contact and colonization experiences, including those that are ongoing, were detrimental to pre-contact ways of existence. Duran asserts that because contact with Europeans was something experienced by all Native American Indian peoples they all also experience the effects of the soul wound to some extent. He goes on to discuss the soul wound's impact on the collective Native American Indian psyche in the following manner,

*"...and it is from this essence that mythology, dreams, and culture emerge. Once the core from which the soul emerges is wounded, then all of the emerging mythology and dreams of a people reflect the wound. The manifestations of such a wound are then embodied by the tremendous suffering that the people have undergone since the collective soul wound was inflicted half a millennium ago. Some of the diseases and problems that American Indian people suffer are a direct result of the soul wound." (p. 45).*

Duran and Duran (1995), Yellow Horse Brave Heart & DeBruyn (1995), and Yellow Horse Brave Heart (1995, 1998c, 1998b, 1998a, 1999) provide a delineation of historically traumatic events that have impacted all Native American Indians since contact. These events are viewed as having a cumulative effect that overwhelms an

individual's and community's psychological resources to the point that these effects become passed on to future generations. The intergenerational effects then become cumulative themselves. These colonizing incidents that underlie the soul wound and subsequent cumulative effects include "themes of cultural and psychological shock, warfare and genocide, systematic oppression and subjugation, decades of forced relocation to reservations, boarding schools and urban areas during termination, and ongoing systematic racism, prejudice, and stereotyping" (Arndt, 2005 p. 6). The delineation of key historically traumatic events represents a summary of the effects of U.S. government policy provided above.

Duran (1990) notes that the occurrence of a traumatic event among Native American Indians in general, is experienced as a disruption from the balanced and intertwined existence that was shared prior to contact. In this way traumatic events, resulting in soul wounding, disrupt the conditions which Native worldview and cultural strengths are based upon. Historically, disruptions were experienced at a very small rate and there were healing ways to heal that rift. Traditionally, these healing ways involved the community and spiritual practices, and each Nation utilized ceremonies and medicines to regain and maintain wellness.

Current traditionally-oriented Native views continue to believe in the need to heal disruptions. The healing is not only for the individual who is suffering. It is also for everything that the individual is related to, and if a disruption is not healed, everything tied to that individual will also become disrupted. The traditional ways are effective for healing on these levels. However, in modern times, it has become more common for Native individuals to be dislocated from the community and from traditional ceremonies

and medicines. Much of this dislocation is a direct result of contact and colonial ways. Connections to these healing ways have been interrupted due to "genocide, warfare, oppression, racism, and discrimination." Also, through US government policies of relocation and boarding schools many Native American Indians have left their historical geographic locations and no longer maintain contact with traditional sites and ways as they once did. This movement has resulted in less knowledge, familiarity and access to cultural knowledge-bearer, healers, medicines and ceremonies. This has also resulted in less knowledge and access to the traditional "holistic worldview of their ancestors."

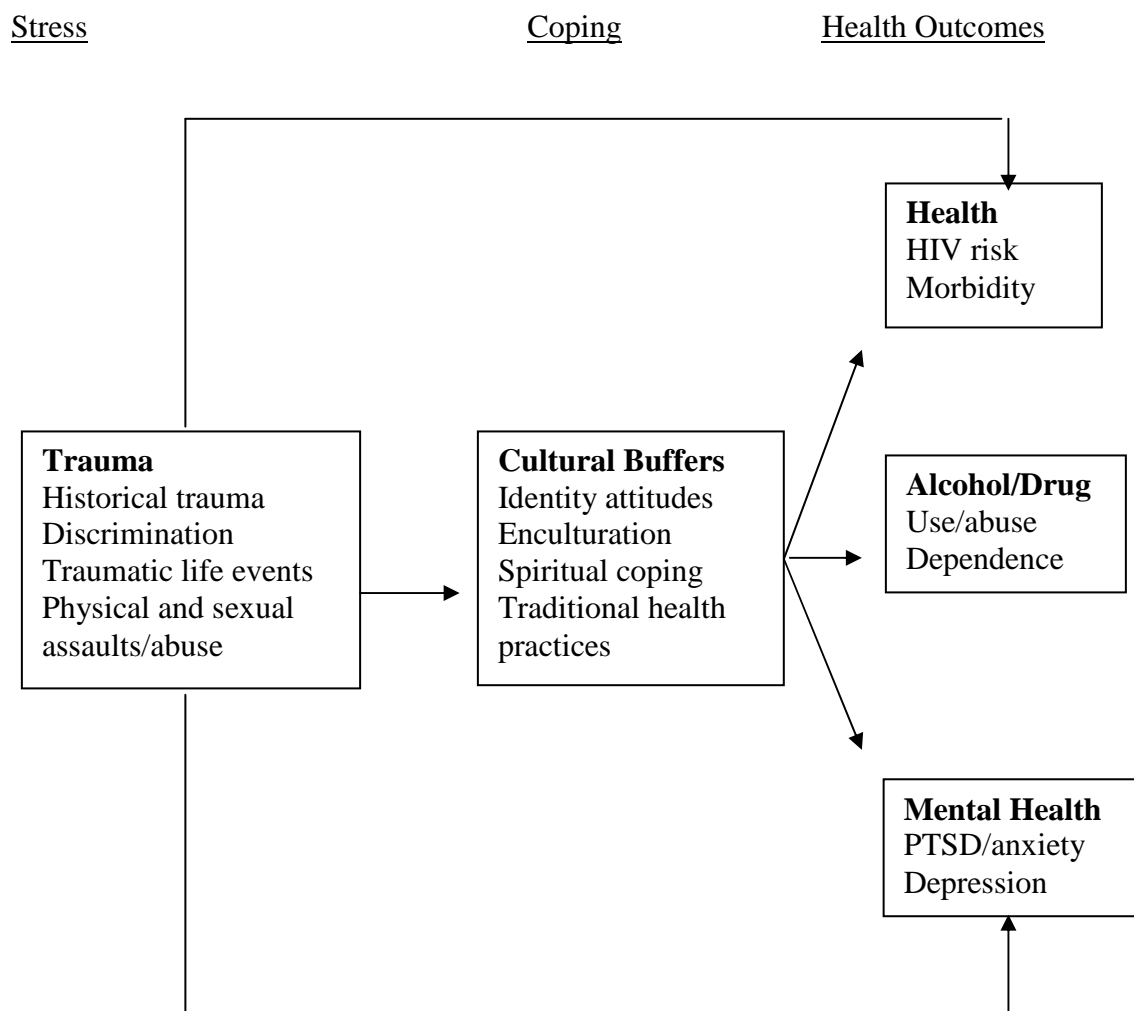
The disruptions due to dislocation exacerbate the trauma of the soul wounding while at the same time denying access to the very ways that could heal these disruptions for individuals and communities. While the effects of colonization have created the soul wound, Western psychology is currently unable to provide a means of healing the wound. This coupled with limited access to traditional Native American Indian healing methods leaves a gap that has resulted in the persistent collective suffering, which has been passed on over generations (Arndt, 2005 p. 8; Duran & Duran, 1995).

Soul wound is a pan-Native view of the impact of common deleterious events and policies that are proposed to continue to negatively impact all First Nations' people. It must be noted, however, that while every First Nation experienced the impact of all of these negative events, they each also had their own unique experiences and reactions to these events. Some First Nations were wiped out and no longer exist, others were able to make some level of peace and suffered for less time than others, and still others were hunted mercilessly for years until they were absolutely forced to surrender being on the brink of extinction.

### *Indigenist Model*

Walters and Simoni (2002) developed an Indigenist model, which was an elaboration of an earlier model of stress and coping (Dinges & Joos, 1988; Krieger, 1999) that incorporated environmental factors including racism and personal identity as moderators of health outcomes. The Indigenist model further incorporated stressful and traumatic events and acknowledged the legacy of soul wound with the intent to be useful in a pan-Native cultural manner. The model also observes that certain cultural buffers such as spiritual coping and traditional health practices can strengthen psychological and emotional health by diminishing the effects of stressors. The Indigenist model (see Figure 1) proposes that the effect of stressors such as soul wound and historical trauma on health is moderated by cultural factors on the outcomes of physical and mental health, and substance use. Other research supports the buffering effect of traditional and spiritually specific healing methods (Buchwald, Beals, & Manson, 2000; Marbella, Mickey, Harris, & Diehr, 1998; Pargament, 1999; Simoni, Martone, & Kerwin, 2002). This model demonstrates that Native American Indians share common values and derive a set of commonly held strengths across the culture. However, this model is not intended to be applied to any one First Nation's culture and is not intended to supercede a specific Nation's cultural strengths.

Figure 1. Indigenist Model of Trauma, Coping, and Health Outcomes (Walters & Simoni, 2002).



In summary, the pan-Native-centric concepts and models about collective soul wound, the intergenerational passage of trauma and stress and coping are the foundations of modern research on Native American Indian mental health and illness. These models provide insight into the origins of modern mental health problems as well as some consideration of the positive effects traditional Native cultures hold. However, these

models represent an early stage of research into conceptualizations of mental health and illness from a Native American Indian perspective. Furthermore, these pan-Native models have not been studied with individual Nations to determine how these concepts apply in a practical manner.

*Mental Health Needs Research Involving Native American Indian Communities*

Few mental health studies have been conducted with First Nations. Those studies will be reviewed next according to method used. To date, the field may have neglected research with Native American Indians due to their small overall population. The First Nations include approximately 1.5% of the United States population who identify themselves as having American Indian or Alaskan Native heritage. The United States federal government currently recognizes 561 distinct Native American Indian First Nations and there are several hundred others that are currently seeking federal recognition. This equates to approximately 4.1 million people and over 200 indigenous languages that continue to be spoken (U.S. Census Bureau, 2006; U.S. Department of Health and Human Services, 1999a; U.S. Department of Health and Human Services, Center for Disease Control, 2005). Previous studies used interviews, diagnostic surveys, and vignettes to collect mental health information.

*Earle and the Haudenosaunee*

Earle (1998) conducted a study specifically focusing on the Haudenosaunee of New York. She used a Western-based mental health survey and found that clinics in Seneca country assumed that Native American Indians did not have mental health needs, and if they did those needs were no different than the general population and required no special services. This assumption is contrary to U.S. government reports that Native

American Indians have much more serious and numerous mental health problems than the general population (National Institute of Mental Health, 1987; U. S. Commission on Civil Rights, 2004). Based in part on her earlier work's findings (Earle, 1996) that many Haudenosaunee people continue traditional practices and these distinct experiences needed to be taken into consideration for those who provide treatment, Earle (1998) then conducted a second part to this same study and created a survey listing spiritual, cultural, and traditional context questions. She found that this survey identified unique mental health needs for the Native American Indians utilizing that clinic. She also determined that Native American Indian clients were more likely to be misdiagnosed than other clients due to cross-cultural misunderstanding and that this likely negatively affected help seeking and service utilization.

This seminal work placed Earle (1998) among the first to document unique mental health needs among Native American Indians, and the Haudenosaunee specifically, using empirical methods. She and others to called for additional work around accurate diagnoses for and an understanding about differences in attitudes toward mental health, both cross-culturally generally and among Native American Indians specifically (Kleinman, 1988; Manson, Shore, & Bloom, 1985; O'Neill, 1989; Price-Williams, 1987). Fortunately, other researchers have answered the call using a variety of research methods. A common method, and the one used in this study, is extended interview.

### *Interviews*

One study that looked at depressive illness in a fashion similar to what was utilized in this current project was conducted with the Navajo Nation. Storck, Csordas,

and Strauss (2000) interviewed Navajo patients who had been diagnosed as depressed by current psychiatric diagnostic criteria. These patients were seeking traditional healing services for their depression. The interview data were intended to elicit an understanding of the symptoms experienced by these patients. Once the patients' experiences were understood, that information was taken to a traditional healer. The healer was asked what he would do with a person who presented with the depressed patient's symptoms in order to determine if a diagnostic label such as depression holds heuristic value in the conceptualization of mental illness in a traditional Navajo setting. While it seemed that the traditional healers did not find that conceptualization and labeling useful, the authors felt that the patients found the labeling of depression useful. The authors also felt that the differences between the biomedical and traditional healing systems were of less significance than their shared existential engagement of mental health concerns.

Theresa O'Neill (1996, 2004) conducted a qualitative study with the Flathead Nation. She asked questions in a grounded theory manner to determine that this Nation was aware of a pattern of symptoms that would likely be consistent with Major Depressive Disorder. However, traditional practitioners there attributed the symptoms to a sadness caused by a particular type of loneliness that had not existed prior to contact with Europeans. O'Neill's results have been interpreted along the line of Duran's conceptual work and the loneliness she found was seen as a result of the negative effects of contact that resulted in mental illness symptoms. In addition, she determined that "loneliness" was not that Nation's "word for depression" (p. 224). Rather, it indicated a culturally-specific meaning of interdependence and existing within a unique social and psychological order. Furthermore, she determined that the illness experience had much



more to do with relationships and belonging than individuals. This loneliness, due to the effects of colonization, marks a disordered social world for this community.

Marbella, Mickey, Harris, and Diehr (1998) used interviews to elicit culturally relevant information from Native American Indians who were seeking mental health services. Based on semi-structured interviews, they determined that 38% of urban Native American Indians being seen at an outpatient clinic were currently using some type of service from a traditional healer. Of those using traditional healing, 61.4% indicated that they rated the healer's advice higher than their physician's and that only 14.8% had told their physician that they were also receiving traditional services. This suggested that many urban Native American Indians report engaging in traditional healing practices when asked on interview.

Similar to Marbella, et al., O'Neill (1998) conducted a case study with one Flathead man utilizing the DSM-IV cultural formulation during a three-and-a-half hour diagnostic interview. The cultural formulation was emphasized by Manson (1995). His recommendations included giving more attention to cross- and within-cultural variations in presentation and the various ways that local cultural idioms are used to express distress. He also noted that there is an ongoing "need to better understand, articulate, and incorporate relevant cultural insights" both in clinical work and diagnostic criteria (487-488). O'Neill relied on her firsthand knowledge of the culture to guide the pace and depth of the interview. She had learned previously how and when to probe for certain information and how to understand specific cultural idioms. It appears that the addition of the cultural formulation is a positive step in the direction of including more cross-cultural information for diagnosis. However, it also appears that one must have at least a

rudimentary level of information about the client's culture in order for that formulation to be effectively useful.

Fleming (1996) also utilized individual interview when creating a cultural diagnostic formulation. She found a number of instances where the client did not feel engaged in previous treatment due to having experiences outside of what that therapist was used to. These experiences included hearing from her deceased grandmother and the barriers that using substances created for attending ceremonies. In addition, the client discussed being fearful of reporting prior sexual abuse and the possibility of someone performing "bad medicine" on her (p. 147). Through interview, Fleming was able to understand the cultural norms around expected reactions and ceremonies related to death. In addition, using substances to cope was understood as was their use being taboo prior to attending ceremonies. Furthermore, the client's fears related to reporting the sexual abuse as being tied to having respect for elders and subsequent fear of bad medicine as reprisal for disrespect.

In summary, these studies demonstrate that interviews are a useful tool to gather data regarding heuristic value of diagnostic labels. These studies also determined that the meaning of symptoms are experienced differently among the Native American Indians interviewed than was meant in the DSM diagnostic criteria. O'Neill's (1996) work showed, the experience of symptoms held a meaning of loneliness and sadness due to the loss of culture since the time of contact where the DSM diagnosed depression.

It is unlikely that other means of collecting diagnostic information would have been able to tap into the constructs specific to each example. The interviews provided a

qualitatively different understanding of the mental illness experience of the participants.

Other methods of study of this phenomenon include survey.

### *Surveys*

There have been some other attempts to study Native American Indian-centric constructs of mental health. A number of researchers used DSM-based diagnostic instruments and found that the results were extremely difficult to interpret. They ultimately determined that those instruments held little value for psychiatric diagnosis with Native American Indian clients.

For example, Eaton, Neufeld, Chen, and Cai (2000) found that the use of the Diagnostic Interview Schedule (DIS) as a self-report diagnostic instrument resulted in an under-detection of mental illness diagnoses when compared to a clinical diagnostic interview such as the Schedules for Clinical Assessment in Neuropsychiatry (SCAN) administered directly by a psychiatrist. The authors concluded that the wording and rating scales used in the self-report measure might have been difficult to interpret for the Native American Indian patients.

In an earlier study, Somervell, Beals, Kinzie, Boehnlein, Leung, and Manson (1993) examined the accuracy of the Schedule for Affective Disorders and Schizophrenia, Lifetime Version (SADS-L) and the Center for Epidemiologic Studies Depression Scale (CES-D) with a Native American Indian sample. The SADS-L interview was conducted first followed by the paper-and-pencil CES-D. It was found that nearly 8% of the participants refused to complete the CES-D. The authors suggested that many of the participants were not comfortable with the paper-and-pencil survey and preferred the face-to-face interview. The authors also found that the CES-D did not

differentiate well between emotional distress and somatic complaints. The authors did not offer an interpretation of these findings except to indicate that the Western-based CES-D would need to be revised to be accurate with this sample.

In a review, Canino, Lewis-Fernandez, and Bravo (1997), discussed the need to ensure that western-based mental health diagnostic instruments hold meaning and value for clients who hold other worldviews. They also discussed the dilemma that altering existing instruments holds and noted that an instrument can only be changed so much before it is no longer able to measure the constructs it was designed to measure. The authors further suggest that clients who hold non-Western worldviews are not as likely to seek help or stay in treatment if there is not a common understanding of mental health treatment concepts. Good (1993) discussed potential cross-cultural problems when diagnostic criteria from the DSM are used. He noted that the much of Western-based mental illness diagnoses are biologically and individually based and the mismatch this creates with clients who do not understand their symptoms within this confines. Furthermore, he points out that people from some cultures are not as comfortable as others in answering some specific questions related to Western-based diagnosis.

One example of an effort to create a culturally-sensitive survey was published in 1985, but the utility of the survey has never been documented (to this author's knowledge). Manson, Shore, and Bloom (1985) proposed to conduct an epidemiological study with the Hopi and sought to develop a diagnostic instrument to identify depression among Native American Indians. The authors pointed out some impediments to developing such an instrument such as the variability among different First Nations, language differences and a manner of interacting with the world that is remarkably

different than American culture in general. Furthermore, they recognized that some First Nations do not have a “semantic equivalent” for depression in their languages (p. 335). Their study indicates that they sought an overarching explanatory model for all Native American Indians, rather than address the variability for each Nation. The authors interviewed thirty-six individuals with questions about illness categories. The questions included asking about what sicknesses there could be, what might cause that, who might get that, what help to get for that, among others. Seven main categories of illness were identified including, (1) personal loss, (2) subsistence difficulties, (3) cultural conflict, (4) interpersonal strife, (5) familial problems, (6) social/political tension, and (7) witchcraft and supernatural sanction. The categories found were not aligned with DSM diagnostic categories.

In summary, the results of these studies indicate that the meanings intended to be conveyed with a Western-based diagnostic instrument are often not congruent with the worldview of a different culture such as Native American Indians. Further, the adaptation of existing Western-based instrument present problems because as one modifies a diagnostic instrument it begins to lose the meaning and accuracy it had with the sample it was created with. It appears that maintaining knowledge about Native American Indians in general may be helpful when applying Western-based diagnostic criteria, and certainly knowledge specific to the client’s Nation is the most useful.

To date, the research has been very limited. The diversity of hundreds of individual First Nations comprising the Native American Indian label may also create a discomfort with this line of research. The diversity within this group limits the

generalizability of the results from a study with any one First Nation to other First Nations. More and better research is needed.

### *Research Into Native Service Usage*

As limited as studies of mental health needs among Native American Indians have been, studies of mental health service usage are even more scarce. A search uncovered only four studies that concentrated on Native American Indians.

Marbella, Mickey, Harris, and Diehr (1998), discussed above, explored the amount of traditional practices that Native American Indians seen in an urban outpatient setting were using. In a different study, Rhoades, Manson, Noonan, and Buchwald (2005) found that 48% of the urban Native American Indians being seen in an outpatient clinic had traveled to their home reservations for traditional healing services.

Novins, Beals, Moore, Spicer, Manson, and the AI-SUPERPPF Team (2004) conducted a study using self-report surveys with patients to determine that the use of biomedical and traditional treatment seeking was a function of level of identity with their Native culture. Traditional treatments include herbal advice, spiritual healing, and sweat lodge ceremonies. The authors found that an individual may use both biomedical and traditional healing systems simultaneously for the same problem at times. A similar study by Gurley, Novins, Jones, Beals, Shore, and Manson (2001) found that Native American Veterans from two separate communities also used both healing systems, but did so based on availability. One community was located near a Veterans Administration hospital while the other was not located near a facility. The veterans from the community near the hospital used those services more often than traveling for traditional services. The community that was not located near the hospital used traditional services more.

These findings indicate that the Native American Indians studied used services, as they were available. Both communities used both types of services.

In summary, these studies highlight the importance of traditional concepts of illness and healing even for those Native American Indians who do not reside within their home reservations. In addition, it was suggested that Native American patients might travel for traditional services because of incongruence between the two systems.

### *Vignettes*

In a search for a succinct means of eliciting culturally sensitive descriptions of mental illnesses, Lloyd, Jacob, Patel, St. Louis, Bhugra, and Mann (1998) developed the a cross-cultural screen called the Short Explanatory Model Interview (SEMI). They used a vignette with interviews in order to establish derive a meaning of symptoms without labeling the experience for the interviewee. The authors' study used a vignette of an individual presenting with somatization and depression. They used follow-up interview questions, based on Kleinman's (1988) explanatory model, to develop the SEMI. Their screen successfully elicited explanatory models from patients who were using primary-care services. The screen explored the nature of the presenting problem along with help-seeking behaviors, beliefs about illness and the patient's cultural background. This was done in order to gather a qualitative description of the patient's experience to provide a more accurate understanding. The authors advocate for the use of the SEMI in epidemiological studies.

### *A Call From the Field*

Currently there are substantial gaps in the literature regarding mental health research with Native American Indians. The previous review documents a need for more

research. However, even more important is research that is culturally informed. Current methods in this area emphasize a general pan-Native approach. This leaves a gap in understanding where individual First Nations are situated regarding mental health. Few studies have attempted to directly determine whether Western-based diagnostic labels hold heuristic values for Native American Indian people. Furthermore, the studies that did explore this conducted interviews with individuals seeking services. This is an important population to gather mental health information from, but these works have neglected speaking with traditional Native practitioners who likely have a different perspective on mental health and illness.

There is a call from anthropologists, cross-cultural psychology researchers and researchers working specifically with Native American Indians (American Psychiatric Association, 2000; Duran & Duran, 1995; Kleinman & Good, 1985; Manson, Shore, & Bloom, 1985; O'Neill, 1989; Sue & Sue, 2003) for more cross-cultural mental health research, utilizing culturally-sensitive methodology, that explores accurate diagnostic criteria that holds value from within the culture. There are a few foundational conceptual pieces that have yet to be built upon.

#### *Native Congruent Ways of Gathering Knowledge*

Eduardo Duran (1990) described pan-Native views of mental health in terms of a "soul wound." Yellow Horse Brave Heart's (1995) work on intergenerational trauma emerged from Duran's (1990) conceptual effort. Both of these authors review the negative impacts of European and U.S. policies on Native American Indians broadly. Duran has made an attempt to extend his soul wound work toward healing (Duran, 2006). However, that work has yet to be shown to be efficacious. Walters and Simoni (2002)



have extended these works into a model of stress and coping looking at the impacts of environmental stresses caused by these negative impacts and including cultural protective factors as moderators of health. This was a needed step toward viewing culture as a source of strength rather than weakness in a blaming the victim manner.

Native American Indian worldview in general is played out in values around holism, interconnectedness, and cooperation in the family and community. Embedded within this worldview is a value on maintaining harmony in relationships with one's self, family, community, Nation and the rest of creation (Duran, 1990). Garret and Walkingstick Garret (1994) agree with that Native American Indian worldview includes a sense of belonging that “relies on...social relationships, as well as a sacred sense of connection with one’s ancestry and tribal history.” The authors further indicated that, “many who are asked to describe themselves will most likely describe some aspect of their family or tribal heritage and affiliation” (p. 136-137). It can be seen that community and family ties are a fundamental source of worth for tribal members, with the definition of family extending well beyond blood ties to the claiming of “fictive” kin and clan members. The orientation is one of process living while embedded within family and community (Arndt, 2005).

Understanding healing from within an individual’s cultural worldview coupled with multicultural competence on the part of the healing practitioner; including a working understanding of the client’s culture and worldview around healing practices is necessary to optimally serve each client (Ibrahim, 1991; Wampold, 2001). Native American Indian worldview is a "systematic approach to being in the world" (Duran, 1990, p. 19). This approach is non-linear and oriented spatially. It focuses on process rather than content.

It is different than the Western way of viewing the world, yet it still uses the same continuum. One must have some understanding of the concepts of holism, balance and non-compartmentalization that are core across Native American Indian worldviews when considering an appropriate method for researching Native-centric health constructs. Generally within the Native American Indian worldview compartmentalization and categorization does not exist and therefore there is no separation of mind, body, and spirit (Arndt, 2005; Duran & Duran, 1990; Manson, Shore, & Bloom, 1985).

Native people tend to "experience their being in the world as a totality of personality and not as separate systems within the person" (Duran, 1990, p. 20). Likewise, there is no loss of connectedness from other non-human systems. Instead there is an emphasis on how everything is related rather than on how things are different. It is acknowledged that all are connected, that everything that has been created has a place within the natural world and that none are above or below other systems or creations. This worldview suggests that in order for one to increase knowledge one must have vigilant and persistent observation and awareness of a whole and complete picture. The process of determining and understanding one's place within all of creation is foundational to all knowledge. This process of observation and awareness of connections and knowledge about these relationships allow for prediction of patterns of behaviors and can be viewed as a methodology for gathering knowledge (Deloria, 1999; Duran, 1990).

Currently the concept of soul wound has not been examined in its entirety and therefore leaves that theory incomplete. In addition, no studies have examined specifically the traditional healer's view of what today are considered mental illness diagnoses. The complexity of this topic and array of directions make this work difficult.

Therefore quantitative methods of study, that would seek to control some factors and manipulate others in an attempt to quantify this unclear area, would be problematic given that it is unknown which constructs and factors are most important and suffer from arbitrariness and lack of direction, which would also make the results impossible to interpret accurately and therefore bring validity into question. There is a need to delineate the mental health and mental illness experiences of Native American Indians in a culturally congruent manner that allows for exploration.

*Methodological Framework: Choosing a Method*

A holistic technique of gathering data contrasts with the empirical reductionist methods currently in use by Western science. Duran and Duran (1995) and Deloria (1999) each provide a critique of Western scientific methods as being restrictive and overly focused on techniques that fail to capture phenomena in their entirety. This seems to be in agreement with Kuhn's (1962) critique of modern science's drive to stay within restrictive confines. Within Native American Indian worldview, broadly, no observance is considered unworthy of attention and therefore would not be labeled as an outlier, considered insignificant, or otherwise be discounted. All observations are considered within the context of inter-relatedness and (dis)order is then determined once that interworking is understood. This suggests that an appropriate method to study Native-centric constructs of health needs to be able to allow broad techniques to capture the entirety and complexity of the experiences.

Structured and semi-structured interviews have been used with patients in attempts to better understand the experiences of Native American Indian patients with symptoms of depression. Most interviews have been conducted with patients rather than

those working to alleviate those symptoms, however. Semi-structured interviews are good instruments for honing in on the qualitative aspects of a construct but may not be the best for allowing the construct to develop spontaneously (Yin, 2003). Vignettes have also been used in order to elicit descriptions of mental illnesses and do not label the experience for the interviewee, which allows for constructs to emerge (Lloyd, et al., 1998).

Using interviews to capture emerging culturally specific views has a history and the field of anthropological psychiatry provides a framework for the types of questions to ask around mental health issues (Hahn, 1995; Kleinman, 1980, 1988). This framework includes exploring the interviewee's experience with mental illness and use of local idioms of distress and care seeking. Questions asked included those about the interviewee's own explanation of the causes, course and treatment of the symptoms.

Kleinman, Eisenberg, and Good's (1978) explanatory model provides specific questions that include, What do you call the problem?, Why do you believe this problem occurred?, How do you think it should be treated?, and Who should one turn to for help and who should be involved in care?. Furthermore, Lloyd, et al. (1998) recommend using interviews with simple language and follow-up probes to explore and confirm constructs. They suggest using the following questions, (1) What if anything is the problem? (2) Does she have an illness? If yes, what is it called? (3) What are the causes of her problem? (4) What should she do? and (5) What should the doctor do about it?. In addition, DSM diagnostic criteria suggest asking questions about characteristics of the mental illness experiences along with questions about deficits, function and dysfunctional

status, and impacts on the four domains of cognition, affect, somatic and behaviors, and attention paid to impairment with life's functioning.

Meaningful results would be difficult to obtain by attempting to reduce the unfolding of Native-centric information to quantitative data. Such an approach implies a circumscribed view of Native American Indian worldview and experience and is in conflict with traditional knowledge attainment methods. The studies reviewed above demonstrated some of the difficulties with attempts to force the diversity of First Nations people, and their interactions with the world, through a strictly Western-based lens. A method utilizing critical ethnography that allows for both deductive and inductive theory development is able to meet criteria for a Native congruent method.

### *Qualitative Methods*

Denzin and Lincoln (1998) indicate that qualitative research emphasizes the study of processes and meanings that are socially constructed. Furthermore, the authors specify that qualitative researchers establish an intimate relationship between the researcher and what is studied. These researchers inquire about answers about how social experience is created and given meaning. Qualitative researchers are allowed to choose from a variety of data collection and analysis techniques (Denzin & Lincoln, 1998). This freedom may be interpreted as lacking in rigor by some. However, interpretive research uses trustworthiness of the results as a measure of credibility rather than seeking objectivity as the hallmark of a quality study (Lincoln & Guba, 1985). Skillfully weaving in and out of data collection, analysis, previous literature and existing theory establishes scientific quality (Creswell, 1998; Miles & Huberman, 1994).

Researchers who use qualitative methods have freedom to choose data collection and analysis techniques. However, this does not mean that they do not utilize specific procedures (Creswell, 2003). The methods chosen are impacted by the discipline, subject matter and nature of inquiry. Furthermore, the methods chosen provide the opportunity to build upon previously used method's strengths and/or address their limitations (Denzin & Lincoln, 1998). Each qualitative method privileges one level of analysis or another. For example, Biography explores one story in one's life, while Phenomenology attempts to understand the meaning of a single experience (Atkinson, 1998; Denzin, 1989; Denzin & Lincoln, 1998). Grounded Theory develops new theories based on emic data (Glasser & Strauss, 1967). Ethnography works to contextualize and study culture-shared systems (Denzin & Lincoln, 1998). Case Studies investigate systems as represented by individuals within an organization. The individuals may or may not be part of a culture-shared system (Creswell, 2003; Denzin & Lincoln, 1994, 1998; Stake, 1995). The Extended Case Method (Burawoy, 1998; Burawoy, Burton, Furgeson, & Fox, 1991; Denzin & Lincoln, 1998) allows the research to draw from various traditions to collect emic data within a broader social context to reconstruct existing theories (Eliasoph & Lichterman, 1999). Table 1 provides a comparison of the first five qualitative methods discussed with the extended case method (see Table 1).

Table 1: Comparison of Qualitative Research Methods with the Extended Case Method

<b>Dimension</b>	<b>Biography</b>	<b>Phenomenology</b>	<b>Grounded Theory Method</b>	<b>Ethnography</b>	<b>Case Study</b>	<b>Extended Case Method</b>
<b>Primary Focus</b>	Exploring the life of an individual	Understanding the essence of experiences about a phenomenon	Developing a theory grounded in data from the field	Describing and interpreting a cultural and social group	Developing an in-depth analysis of a single case or multiple cases	Reconstructing context driven theory using data from the field
<b>Discipline origin</b>	Anthropology Literature History Psychology Sociology	Philosophy Sociology Psychology	Sociology	Cultural Anthropology -Sociology	-Political science -Sociology -Evaluation -Urban studies -Social sciences	Interdisciplinary: -Sociology -Political science -Anthropology
<b>Data Collection</b>	Primarily long Interviews	In-depth interviews with up to 10 people	Interviews with enough individuals to “saturate” categories and detail a theory	Primarily observations and interviews with additional artifacts during extended time in the field (6 months – 1yr)	Multiple sources: -Documents -Archival records -Interviews -Observations -Physical artifacts	Multiple sources: -Interviews -Archival records -Documents -Observation -Social/political mvmts -pop culture
<b>Data Analysis</b>	Stories Epiphanies Historical content	Statements Meanings Meaning themes General description of the experience	-Open coding -Axial coding -Selective coding -Conditional matrix	Description Analysis Interpretation	-Description -Themes -Assertions	-Context-driven description -Thematic analysis and reconstructing existing theory
<b>Narrative Form</b>	Detailed picture of an individual’s life	Description of the “essence” of the experience	Theory or theoretical model	Description of the cultural behavior of a group or an individual	In-depth study of a “case” or “cases”	Identification of pre-existing theory’s limitations to explain unique findings, and reshaping theory to address these inadequacies.

Source: Samuels, 2008.

The methods included above only represent six of the numerous qualitative approaches. This was included to provide the reader with a brief reminder of the scope of these common methods.

#### *Extended Case Method*

The extended case method (ECM) was designed to “confront the empirical realities of social process and their contribution to the state of social order.” ECM accomplished this by building upon the strengths of other qualitative methods and provides for a “clear and specific empirical focus without pre-judging this focus theoretically or ideologically” (Evens & Handelman, 2006, p. 2). Burawoy et al. (1991) indicated that the traditional anthropological stance of using ethnographic data from a distanced perspective is limited, as is positivist striving for a purely objective lens. They instead advocate for neither immersion nor distance from the investigator, and note that the goal of fieldwork is to discover and possibly change researcher biases through interaction with the participants and their context. The extended case method seeks more of a collaborative approach during data collection and analysis in order to delineate and understand the nuances and particulars of the data. None of the data are considered outliers or anomalies (Burawoy, 1998). The primary aim of the ECM is to reconstruct existing theory by understanding macro level forces as they are made manifest through individual lives, such as with exploring how cultural tenets are played out within an individual’s work in a community (Burawoy et al., 1991; Samuels, 2008). For examples of ECM applied see, Camino (2000), Roysircar (2004), Salyers and Rithchie (2006), and Samuels (2008, 2009).



The use of ECM provides an opportunity to improve upon the limitations of earlier studies of Native American Indian constructs of mental health and illness (Canino, Lewis-Fernandez, & Bravo, 1997; Eaton, Neufeld, Chen, & Cai, 2000; Fleming, 1996; Guillory, Willie, & Duran, 1988; Lloyd, et al., 1998; Manson 1995; Manson, Shore, & Bloom, 1985; Somervell, Beals, Kinzie, Boehnlein, Leung, & Manson, 1993; Marbella, Mickey, Harris, & Diehr, 1998; Novins, Beals, Moore, Spicer, Manson, and the AI-SUPERPFP Team, 2004; O’Neill 1998, 1996; Rhoades, Manson, Noonan, & Buchwald, 2005; Storck, Csordas, & Strauss, 2000; Wakefield, 1999). The use of a vignette and semi-structured individual interviews viewing each of the participants as individual cases builds upon the strengths of previous research by allowing for the direct collection of the voices of those involved with healing.

This current study responds to the calls for culturally relevant means of understanding mental health issues among Native American Indians. The studies reviewed were all conducted on rural reservations in the Western United States or in an urban setting. Also, the traditional services used required the use of a single healer, or “medicine person.”

The present study focused on the On̓ayoteʔa·ká, who historically lived in what is now upstate New York and southern Canada and currently live within three main communities. The On̓ayoteʔa·ká of upstate New York and Ontario are small communities and would be considered rural. The On̓ayoteʔa·ká community in Wisconsin, however, is in a location that borders two cities with populations of approximately 105,000, and 22,000. The On̓ayoteʔa·ká in Wisconsin are located within close proximity to these cities, but would not technically be considered an urban setting

because they do not reside within the city limits of the larger city. It is likely that the previous research that focused on rural Native American Indians will be more applicable than that focusing on urban areas. None of the individual communities would qualify as urban and therefore likely differ from the urban Native American Indian participants who were studied in some of the reviewed literature.

In addition, the previous studies also differ from this current study because the OnΛyoteʔa·ká do not have a traditional healing system wherein one individual can be sought for services. The OnΛyoteʔa·ká traditionally have a number of people in the community to provide education in an attempt to prevent and/or treat problems of conflicts, role transitions, and grief. Moreover, there are small medicine societies who have been chosen by healing spirits to alleviate physical, mental, emotional and spiritual problems. Healing is always conducted in groups and not by one individual medicine man (Elm & Antone, 2000; Mitchell, Barnes, Thompson, Mitchell, Thomas, & Buck, 1994; Mohawk, 2005; Shenandoah, & George, 1998; Shimony, 1994). Both the settings and application of traditional healing in previous studies are different than the circumstances with the traditional OnΛyoteʔa·ká, and therefore those studies will only be applicable insofar as their framework can be adapted to the current study.

Traditional OnΛyoteʔa·ká cultural experts are important cases to study because they can offer insights into their conceptualization of depressive symptoms. The OnΛyoteʔa·ká are one of the First Nations that reside within the state of Wisconsin and are therefore included in the over-represented and underserved mental illness data, including being diagnosed with DSM criteria and labels at an alarming rate. This study explored the traditional OnΛyoteʔa·ká view of mental health, illness and *depression*

specifically. In addition, points of convergence and divergence between the Onʼlayoteʼaʼká and DSM diagnostic systems of understanding mental health were explored. This study worked to translate a bridge between the traditional Onʼlayoteʼaʼká and Western or DSM worldviews in order to better understand cross-cultural applications of psychology as well as elucidate tenets and values from a traditional Native American system of working with symptoms consistent with a DSM diagnosis of major depressive disorder. This study also explored the diagnostic label of major depressive disorder in order to determine whether it is useful diagnostically in the traditional Onʼlayoteʼaʼká system. This was done in order to better determine whether the constructs captured in a DSM-based diagnostic label hold similar meaning to that of the mental health experiences of Native American Indians, and the traditional Onʼlayoteʼaʼká in particular.

This study employed the Extended Case Method and conducted semi-structured individual interviews with seven individuals who were involved with traditional Onʼlayoteʼaʼká culture, healing, and language. These interviews were used as case studies and a thematic analysis was performed to enhance an understanding of traditional Onʼlayoteʼaʼká conceptualizations of depressive symptoms as well as mental health and illness constructs in general.

*ECM applied to the present study.* Extended Case Method (ECM) (Burawoy, 1998; Burawoy, Burton, Ferguson, & Fox, 1991) was the method used for this study. Utilizing ECM to explore traditional Onʼlayoteʼaʼká constructs of mental health, illness and *depression* is a response to the call for further cross-cultural research in Native American Indian mental health constructs (American Psychiatric Association, 2000;

Duran & Duran, 1995; Kleinman & Good, 1995; LaFromboise, 1990; Manson, 1985; O'Neil, 1989).

### *Methodological Framework Summary*

The qualitative research method and techniques used in this current study provided a culturally congruent means of data collection. Extended case method was chosen because of its flexibility to allow whatever data gathering technique is most appropriate. In addition, ECM utilizes both inductive and deductive analysis, which facilitates a comparison of existing theory with emergent themes. Semi-structured individual interviews were conducted by an insider-expert. This is a technique that compliments the oral tradition of Native American Indian cultures, and face-to-face meetings in a story-sharing format is a cultural expectation.

ECM is ideal for further development of existing theories to better meet the needs of marginalized and other populations. Data collection techniques and theory are interrelated, but independent of each other. ECM allows the researcher to gather data through the techniques that are most appropriate for a local culture in order to study a broader phenomenon or theory. This allows the use of culturally congruent methods to study existing and emerging phenomenon. Furthermore, ECM utilizes both inductive and deductive interpretation of data simultaneously in order to reconstruct existing theory while being sensitive to emerging and culturally specific explanations. Moreover, ECM provided for the investigation of data from a perspective within each of the participants. ECM emphasized theory extension and development, which enabled this study to expand the applicability of the foundational pan-Native work onto one specific Nation in order to better determine how relevant the theory of soul wound is to health and healing for a

traditional Onʼayoteʼa·ká situation. This flexibility lent itself well to the endeavor of researching Onʼayoteʼa·ká healing cases. This method allowed for the investigation of Native and Western-based mental health literature and was able to mesh those data with information collected from individual cases through in-depth semi-structured interviews. This line of research is at its beginnings and conducting qualitative interviews with this population of traditional Onʼayoteʼa·ká healers served as an excellent technique for gathering relevant phenomenological information.

*Insider-experts.* Research on the topic of mental health from a traditional Native American Indian viewpoint is sparse, however, the works on foundational pieces have been completed by academic Native American Indians themselves (Duran, 2006, 1990; Duran & Duran, 1995; Duran, Duran, Yellow Horse Brave Heart, & Yellow Horse-Davis, 1998; O’Neill, 1989, 1996, 1998, 2004; Walters & Simoni, 2002, 2009; Yellow Heart Brave Horse, 1995, 1998a, 1998b, 1998c; Yellow Heart Brave Horse & DeBruyn, 1995). Their insider status has brought invaluable expertise to their studies. In fact, it can be argued that only an insider can fully understand culturally specific experiences and attempt to translate those into another worldview (Arndt, 2005). Shweder (1993) cautions that, "The process of understanding the consciousness of others can deceptively appear to be far easier than it really is" because when attempting to understand one begins with comparison to their own familiar experience (1993, p. 428). O’Neill (1996, p. 178) explains further that, "... the assimilation of other's experience to one's own is commendable; yet it is inadequate for a rigorous accounting of the phenomenology..." Duran and Duran (1995) agrees that experiences are socially mediated and those steeped in the social context are in a position to interpret culturally-specific meaning. Despite

these noted difficulties the above authors, and this primary investigator, continue to work to translate worldviews. The reader will need to be aware of this difficulty and their own role in keeping an open mind to the interpretation of the results.

Native American Indian academics have been able to bring the knowledgebase formally held by the immersed researcher, but have been able to also gather information objectively in the vein of the distanced researcher (Kanuha, 2000). ECM does not interpret the role of the insider-expert researcher as dichotomized, distanced versus immersed, but conceptualizes the researcher as a uniquely informed, objective scientist. Research is viewed as a process and an interaction wherein a knowledgebase is constructed (Burawoy, 1998). This conceptualization of research is congruent with Native American Indian theory of information gathering, wherein all knowledge building is a process, dynamic, relational, and is transforming to all involved (Deloria, 1999; Peat, 2005). It is asserted that this researcher's insider status will enhance the unfolding of the research process in both the ECM and Native American Indian traditions. The primary researcher's insider status, as a participant observer, brings invaluable expertise to the project. This status, including firsthand knowledge of cultural traditions, history, ceremonies and Onʼayoteʼaʼká language, enhanced the unfolding of the research process in both the ECM and American Indian traditions. This ability will assist the academic community to view the results with integrity while allowing the cultural community to understand the results as helpful rather than exploitative and divorced from real issues and real-life problems (U.S. Department of Health and Human Services, 2001). The method proposed for use with this study, discussed below, utilizes several levels of rigor to protect against potential biases due to the researcher's insider status.

*Data collection techniques.* In order to understand the On'ayote'a'ká cultural worldview regarding mental health and depression, the chosen technique of data collection within the ECM framework for this study was that of semi-structured individual interviews rather than self-report surveys or questionnaires, which have been found to be unreliable due to not holding the same meanings when applied cross-culturally (Canino, Lewis-Fernandez, & Bravo, 1997; Eaton, Neufeld, Chen, & Cai, 2000; Good, 1993; Kleinman, 1988; Manson 1995; Manson, Shore, & Bloom, 1985; Rogler, Malgady, & Rodriguez, 1989; Somervell, Beals, Kinzie, Boehnlein, Leung, & Manson, 1993; Wakefield, 1999). The research reviewed in this document left the impression that structured or semi-structured interviews have been the most successful methods used to engage an individual's understanding of his or her experiences. Semi-structured interviews allow for a more in-depth and personal engagement of the topic by providing the interviewees the opportunity to expand on their responses to add to the richness of the information gathered.

Previous studies reviewed have conducted research, including interviews with distressed individuals. Although distressed individuals who are seeking services have a valuable perspective, those who are providing the services have a valuable perspective as well. It can be imagined that distressed or disordered individuals have a skewed sense of reality, however that is defined within their local culture, and therefore the information that they provide may be valuable, but will likely not be an accurate depiction of the constructs of mental health. For example, someone involved with healing a symptomatic individual may very well have a different perspective than the individual who is symptomatic. The healer will likely have a perspective embedded within a model of

normative health while the symptomatic individual will likely have a perspective focused on the symptoms. Western and Native-centric literature was reviewed to guide the creation of interview questions in order to augment theory development.

The present study used a DSM casebook vignette of major depressive disorder adapted from Getzfeld (2004) to ensure that the four dimensions of depression including 1) cognitive, 2) affect, 3) behavior, and 4) somatic are equally represented. Open responses to the vignette were followed up with a semi-structured interview with follow-up probes to compile case study data. The interview questions, taken from Lloyd, et al's. (1998) work with the short explanatory model interview, and from DSM-IV-TR diagnostic criteria, can be found in Appendix D.

This method of case study data collection, which views all gathered information as important, is congruent with Native American Indian worldview for acquiring knowledge about the interface between worldviews. This study attempted to integrate areas of history, anthropology, sociology, First Nations studies, linguistics and cross-cultural psychology by utilizing data from a literature review that included culturally specific sources, an investigation into the Onʔayoteʔa·ká language and interview data from participants who are involved with traditional forms of health and healing. Participants' cultural and communal histories were collected utilizing a form designed to gather demographics and self-identity information along with interview questions specific to their roles within the traditional community and how they themselves came to have the knowledge they shared. Semi-structured individual interviews were audio-recorded to gain a sense of each interviewees' experiences with Onʔayoteʔa·ká-centric health and healing.



Information gathered from these interviews with traditional On̓yoteʔa·ká experts involved with healing and culture will be used to set the historical and contemporary stage for understanding the On̓yoteʔa·ká worldview and conceptualizations of mental health. An interview with an On̓yoteʔa·ká language expert will be explored to assist in understanding the local cultural expression and interpretation of experiences with mental health, illness and depressive symptoms. Information gathered from these interviews will help to determine the points of convergence and divergence between traditional On̓yoteʔa·ká and DSM-IV-TR conceptualizations of major depression, including illness constructs and treatment factors. In addition, if a condition that would be defined by the DSM-IV-TR as major depression exists among the traditional On̓yoteʔa·ká insights into the social impacts, etiology, nosology and course should be uncovered. It is hoped that this project will have impacts in furthering a framework for understanding cross-cultural work and for assisting with appropriate interpretation of the psychological experiences of the traditional On̓yoteʔa·ká.

#### *Aims of the Present Study*

Initial efforts in the area of Native-centric mental health theory suggest that foundational pieces need to be extended into (1) healing and wellness, and (2) specific Nations' application. One of the purposes of this current study is to extend this scant literature with some application with a specific First Nation rather than in a pan-Native fashion. The primary aim of this study was to explore points of convergence and divergence between traditional On̓yoteʔa·ká and Western conceptualizations of mental health, mental illness and symptoms of major depressive disorder. One of the questions addressed in this investigation was how do traditional On̓yoteʔa·ká health practitioners

conceptualize symptoms that would meet DSM-IV-TR criteria for diagnosis of major depressive disorder. Likewise, information was sought to explore the similarity between the systems on dimensions of mental health and illness in general including the role of community and whether the OnΛyoteʔa·ká system includes more or less considerations when constructing an understanding of symptoms and healing.

The second aim of this study was to determine whether Western-based diagnostic label of depression held heuristic value for traditional OnΛyoteʔa·ká. This investigation attempted to examine and interpret these constructs using a method that is congruent with Native American Indian indigenous methods of information gathering. In order to address these aims the worldview and local cultural health and healing idioms used by the traditional OnΛyoteʔa·ká were explored using a vignette and semi-structured individual interviews with traditional practitioners. These views were used to describe and interpret experiences with mental health and illness in order to provide a point of departure from the DSM-IV-TR conceptualization of depression.

The results of this project may implications for fields outside of clinical psychology in that several fields of inquiry (e.g., anthropology, history, linguistics and First Nation Studies) were utilized to guide its direction and analysis. Implications specific to the field of clinical psychology include extending the theoretical, research and practical knowledge bases for cross-cultural conceptualizations of mental health, illness and *depression*. The present study attempted to at least partially answer the calls of researchers in diverse fields, who have urged that the current state of Native-centric health research be explored in a holistic manner congruent with Native American Indian methods and values on a Nation-by-Nation basis.

## CHAPTER 3.

### Method

This study employed the Extended Case Method. A vignette was presented of a woman reporting symptoms consistent with major depressive disorder. The vignette was followed by semi-structured individual interviews with seven individuals who were involved with traditional On̓ayoteʔa·ká culture, healing, and language. These interviews were used as case studies and a thematic analysis was performed.

#### *Participants and Participant Recruitment*

Nomination and snowball sampling played a major role in the recruitment of participants. Interviewees were recruited through personal contacts with traditional On̓ayoteʔa·ká people who are involved with traditional culture, language, and healing. This included individuals employed at the Oneida Cultural Heritage Department, which is involved with historical archiving, maintaining and revitalizing traditional On̓ayoteʔa·ká culture and language. Employment at the department indicates community acknowledgement of expertise in traditional cultural knowledge and practices.

Those people who were first contacted were approached in person with a gift of oyukwaʔu·wé (indigenous tobacco) as respect and thanks for the recruitment opportunity. These first contacts were asked to identify others they thought would contribute to the project in meaningful ways. Two additional interviewees were identified in this manner and were approached in the same manner. All six cultural participants accepted the gift of oyukwaʔu·wé and agreed to participate. In addition, an expert of On̓ayoteʔa·ká language and linguistics, who is employed at a local university, was approached and

agreed to be interviewed as a means to determine the amount of congruence the On̓ayoteʔa·ká language has with DSM diagnostic terms.

The sample included six men and one woman from various backgrounds including roles of traditional Chief, Faithkeeper, language expert, and people who were involved with community health. The participants thus represented an exhaustive pool of traditional On̓ayoteʔa·ká language, culture and healing experts. The principal investigator of this study is a traditional On̓ayoteʔa·ká community member and insider relative to traditional cultural knowledge and basic On̓ayoteʔa·ká language skills. However, the principal investigator has never been employed at the Oneida Cultural Heritage Department.

*Demographic survey.* A brief survey to determine some of the demographic characteristics of the interviewees was developed (see Appendix B). The participants reported ages ranging from 36 to 65 years. The participants self-identified as Oneida, On̓ayoteʔa·ka and/or Longhouse when asked about ethnicity and religion. (The term Longhouse is used to refer to the traditional people within the Oneida community. The term Oneida is what has become common in English when referring to the On̓ayoteʔa·ká people). The participants were asked about whether they were willing to have more identifiable information presented. However, due to the small size of the exhaustive pool, some were not willing to have more identifiable information printed and thereby risk being individually identified. The researcher therefore decided that none of the participants would be identified in greater detail than just presented. Likewise, the quotations that are presented in the Results section are consistently identified across quotations (i.e., the same persons were identified across their statements). However,

which person is making that statement (e.g., the traditional Chief, the Faithkeeper) is not identified.

*Vignette.* A vignette of major depressive disorder was adapted from Getzfeld (2004) and included two symptoms from each of the four areas of cognition, affect, behavior and somatization that are prevalent in major depressive disorder (Manson, Shore, & Bloom, 1985; cf. DSM-IV, APA, 1994). The vignette, found below and in Appendix C, was used for the context of the first set of interview questions.

*“The person who comes to you is a forty-three year old woman. She has been married for 12 years and they have one ten year-old daughter. She works as an engineer and her husband works as an accountant. The woman has one younger brother who she rarely sees. Her mother is a homemaker and her father is a contractor.”*

*“When she arrives, she is causally dressed, well-groomed has glasses and a wedding ring. Her eyes are red and swollen, as though she had been crying before she came in. In her words, her reasons for coming in to see you are, ‘It’s been weird for me lately, feeling sad and discouraged all the time. It’s gotten much worse in the last year. I sleep more and sometimes wake up in the middle of the night and am unable to fall back asleep. My appetite has gone. I feel empty and hopeless. I find it difficult to pay attention at work. Sometimes I think that life is not worth the constant hassle and effort. My energy is totally drained. Nothing’s fun in my life.’ She then states that, ‘I came in to see what’s wrong.’”*

### *Interviews*

Extended Case Method is flexible and encourages the use of data gathering methods that are culturally-congruent with traditional Native American Indian information-gathering practices. Consistent with extended case methodology, it also accommodates variations in participant’s individual cases. This method allows for a process orientation to data gathering, and honors the relational perspective of the Native American Indian tradition (Arndt, 2005). The semi-structured individual interviews with the participants were conducted in a conversational manner in order to provide answers

specific to the study's aims while also facilitating the gathering of additional culturally specific information.

The interviews were conducted in the English language. All of the interviewees were fluent in English, but not all were fluent in Onʌyoteʔa·ká. In addition, the principal investigator is not fluent in Onʌyoteʔa·ká, which would have made spontaneous exploratory questions difficult or impossible. After reading the vignette of someone presenting with symptoms consistent with Major Depressive Disorder, the interviewees were asked the same standard questions (Appendix D). The interview covered conceptions of mental health and mental illness, as well as exploratory follow-up questions based on emerging topics pertinent to this study's aims. The interview questions are displayed in Table 2 where they are listed under their corresponding analysis theme in an attempt to assist the reader understand how the interview questions and analysis themes are conceptualized in this paper (see Table 2).

All seven interviews were audiotaped. Several phone calls were made for follow-up questions wherein the interviewer made notes. As noted previously, participants were encouraged to answer all questions but were advised that they could choose to pass over any question they did not want to answer, and could also terminate the interview at any point. Before ending the initial session, arrangements were made for the possibility of follow-up questions in the form of face-to-face or telephone contact. Four of the six cultural interviewees responded to follow-up questions to clarify responses. The other two did not respond to a request for follow-up.

Table 2. Interview Questions For Each Main Theme

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Illness Constructs

(Epidemiology: etiology, prevalence, nosology; Definitions: problem, name, severity)

- What if anything is the problem? If yes, what is it called?
- Is it an illness?
- What are the presumed causes?

Treatment Factors:

(Course & outcome, risk and protective factors; Treatment issues)

- What should she do about it?
- What should someone else do? And, who would that be?
- What would be the Course & Outcome of treatment?
- How would she and the person treating know when to stop treatment?

Community Impacts:

(Positive and negative on individual, family, community, etc.; Historical vs. contemporary effects)

- What are the implications for the community of a healthy or well individual?
- What are the implications for the community of an unhealthy or not well individual?

General Mental Health and Mental Illness:

- Characteristics of someone who is mentally un/healthy?
  - Does someone who is mentally un/healthy have deficits?
  - Does someone who is mentally un/healthy have dysfunction?
  - How does one become unhealthy?
  - How does one become healthy again?
  - Does conceptualization of mentally un/healthy consider the four domains of: Cognitive, Affective, Somatic, Behavior?
-

### *Procedure*

Each of the research participants was contacted by phone. During this initial phone contact the project was briefly described and questions were answered. In addition, a time to meet face-to-face at the participants' convenience was scheduled. At the face-to-face meeting informed consent (Appendix A) was explained and questions about informed consent and the project were answered.

The informed consent form detailed the structure and purpose, risks and benefits of participation, confidentiality and voluntary nature of the study. In addition, participants agreed to have their interviews audiotaped. Participants were advised that they had the option of refusing to allow their history-gathering and interview sessions to be audio and/or video recorded, and could also stop such recording at any point. Upon agreeing to take part in the study, participants signed the informed consent forms and completed the demographic survey. Each interviewee was then provided with a typed copy of the vignette and asked to read it. They were asked to give their impressions about it, given the semi-structured interview, and spontaneous follow-up questions were asked by the primary investigator.

*Analysis.* The analysis process was both inductive and deductive, which is one of the strengths of the Extended Case Method. That is, the method allows for building upon existing theory using emerging ethnographic findings. Delineating constructs utilizing other methods of inquiry is restrictive when one attempts to remain faithful to Native American Indian worldview and to knowledge gathering methods that utilize all data. Received Native-theory offers a holistic model that seeks balance and harmony and does not separate constructs from the whole experience (Arndt, 2005). This includes concepts



of non-compartmentalization and viewing events in life in a non-linear spatial manner that is not bound by time (Duran, 1990, 2006; Duran and Duran, 1995). However, in an attempt to advance multidisciplinary research methods and increase cross-cultural psychological research with Native American Indians, several constructs from previous works were identified. These constructs include considerations of the impact of historical and current events that fall under the designation of soul wound (Duran, 1990). These considerations attend to positive and negative cultural moderators, including practice and loss of traditional healing rituals that impact physical and mental health outcomes (Walters & Simoni, 2002). It should be noted that these constructs revolve around holism, interconnectedness and non-compartmentalization, as well as harmony and balance. Attaining these constructs in a positive manner is seen as healthy, while disruptions to these are considered as one source of unhealthiness.

#### *Researcher Influence on Analysis*

The primary researcher was involved in every phase of this study's conceptualization, data collection and analysis, including conduct of the interviews. He brought with him a personal history of soul wound as a person of biracial, White/Onʌyoteʔa·ká heritage. Additionally, the primary researcher has been working with the Onʌyoteʔa·ká culture and language revitalization program for more than ten years including travel to other Haudenosaunee Nations for healing and leadership purposes. He also spent seven years studying as a doctoral student in clinical psychology. This provided him the perspectives of both an academic and an insider-expert.

### *Analysis and Interpretation*

A thematic analysis was undertaken to examine the data. Themes are defined as reasoned descriptions derived from patterns within the data (Taylor and Board, 1984) and are able to bring together pieces of the data that “often are meaningless when viewed alone” (Leininger, 1985, p. 60). Once the interview data were collected and transcribed, responses were organized into patterns, which were then built into sub-themes (Aronson, 1994). This involved organizing data quotes to fit the themes identified by the interview questions, which were based on the explanatory model of Kleinman, as well as diagnosis of depression according to the DSM. In addition, the data were reviewed for emerging ethnographic themes. This involved searching for patterns in the responses that fit together to form a cogent description of the interviewee’s collective understanding of the symptoms, and mental health concepts in general (Leininger, 1985). When patterns, sub-themes and themes were identified, those findings were reviewed with available interviewees, in accordance with the actions of qualitative analysis experts (e.g., Aronson, 1994; Lincoln and Guba, 1985; Yin, 2003).

The transcripts were analyzed for domain themes and subthemes around mental health, illness, healing, and symptoms of *depression*. The researcher’s handwritten notes were analyzed in the same fashion. All data were analyzed both within-case and cross-cases. Data categories were initially predetermined by DSM and Western psychological constructs including epidemiology, treatment, functioning, and costs associated with depression. Categories were also predetermined by questions designed to elicit illness explanations. Additionally, Onlayote’a:ká themes around constructs about health, illness and healing emerged during analysis.

*Qualitative steps.* Creswell (2003) recommended a six-step process for the analysis and interpretation of qualitative data. The first step is to organize and prepare the data. This includes transcribing the recordings and conducting a process of general scanning, sorting and arranging the data. The second step is to read through all of the data to gain a general sense of themes and concepts. Step three is the beginning of reducing the data. In this step the transcripts are reduced to chunks but are kept in vivo (i.e., original) terms. The fourth step is a process of creating a more detailed rendering of the data by generating descriptions, categories and themes. This process leads to the presentation of descriptions and themes in narrative form along with representative quotes of the data in step five, which is presented in the Results chapter. The final step is to provide an interpretation of the data through the context it's embedded within as well as with the existing body of knowledge in the area of study. This step is presented in the Discussion chapter.

*Step 1: Organizing and preparing the data.* Organizing and preparing the data involved the interviews each being transcribed verbatim by the primary researcher. The typed transcripts ranged in length from nine to twenty-seven pages and averaged eighteen pages per each of the seven interviews for a total of 126 single-spaced pages of transcribed interview data. The interviews took between forty and 130 minutes. The total number of minutes of interview time was 600, with an average of approximately 85 minutes per interview. Five of the seven interviews were completed in one session, and the other two were completed in two sessions. All of the transcripts were read in their entirety by the primary investigator. Furthermore, each interviewee was provided with a copy of his/her transcribed interview data for review prior to analysis to generate any

additional information or clarification that participant wished to provide. No additional data were received from any participant. The interview questions were designed to guide the emergence of categories and themes. However, this scanning process, in this first step, was valuable for determining that some of the interview responses would need to be realigned for a better thematic fit.

*Step 2: General themes and concepts.* The primary investigator's reading and rating of all of the transcripts provided a general sense of that data and with identifying sections of data that did not clearly align with one or another interview question. This mental mapping provided a guideline to organize the concepts presented in the raw interview data into initial themes and categories.

The traditional healers' transcripts were also read and rated by two academic and three community analysts. The academic analysts, who were members of the dissertation committee, read all six of the transcripts. One of the academic analysts was the committee chair and the other was a committee member most familiar with Native American Indian qualitative research. That committee member was an insider to the Native American Indian community, but not to the Onʼayoteʼa ká specifically. The community analysts read two transcripts each. The community analysts were identified as having a background in traditional health and traditional cultural knowledge, and basic Onʼayoteʼa ká language skills. These community analyzers were not interviewed for this study but acted as insider consultants. The analysts were given the instructions to read the transcripts and mark areas that they found interesting and/or important. They were also asked to make written notes to clarify their choices. This process identified the initial categories and themes.

*Step 3: Chunking the data.* The data were then reduced by placing the interviewee's original responses into each category and theme heading. Some responses to interview questions were taken as chunks of data and moved to other categories. Longer responses were searched for sections of quotes that captured the essence of what was being conveyed. These shorter sections were used in the final themes. This resulted in a more detailed representation of the data within the identified themes.

*Step 4: Detailed themes.* The themes and categories were identified via an iterative process wherein the data were viewed using one representation and then read through by the primary investigator to determine how well that representation fit. Eleven iterations were undertaken prior to determining the final set of themes and categories. As previously noted, the fifth and sixth steps of Creswell's process are reported in the Results and Discussion chapters, respectively.

#### *Standards of Quality and Verification*

Lincoln and Guba (1985) established four criteria for establishing the trustworthiness of the findings from qualitative data. These include (1) credibility or confidence in the accuracy, (2) transferability or demonstrating that the findings can apply in other contexts, (3) dependability or demonstrating that the findings are consistent, and (4) confirmability, which ensures that the findings are based on the data rather than researcher bias. Lincoln and Guba (1985) also provide techniques for establishing these four criteria.

*Credibility.* Techniques for establishing credibility include (1) prolonged engagement in the field, (2) persistent observation, (3) triangulation of sources, (4) peer debriefing, and (5) member-checking (Lincoln and Guba, 1985). The primary researcher

is a member of the traditional Onʼayoteʼa·ká community and has been studying the language and culture for the past thirteen years. Interviews were conducted with individuals involved in various facets of traditional healing as well as Onʼayoteʼa·ká language ability. Observations across interviewees were essential with adding richness to the data. Multiple fields of study including history, anthropology, linguistics, First Nation’s studies and psychology were included as sources for this project. Written materials were referenced to provide a context for the interview data.

This project was discussed with academic and non-academic colleagues as a means of peer debriefing. Input on the analysis process was solicited from the interviewees. This process is called member-checking (Yin, 2003) and is considered essential for ensuring cultural accuracy and sensitivity (Leininger, 1985). Member-checking was conducted with the interviewees on an ongoing basis to ensure cultural accuracy. These contacts included phone calls, face-to-face conversations and emails addressing questions about the data and analysis. Providing the analysis to the participants is considered a critical means of establishing trustworthiness and credibility (Lincoln and Guba, 1985).

The interviewees were presented with the final set of themes and subthemes for their review. Again, no additional data were received from any participant and the participants assured the primary researcher that nothing important had been left out and that nothing had been stated that should not have. There was no disagreement on the final set of themes and subthemes. There were also no recommendations for addition or deletions to that set. Notably, several of the interviewees indicated that the core tenets of the traditional Onʼayoteʼa·ká culture be focused on so that readers would better

understand the different worldview being offered. One of those interviewees in particular suggested that if the core tenets could be conveyed then the reader would understand an Onʻyoteʻa ká-centric view of the people and their intended experiences with health even without viewing the data or interpretation.

*Transferability.* To establish transferability, the analyses utilized thick descriptions (Lincoln and Guba, 1985). This refers to providing a detailed context for the findings to fit within. Thick descriptions are contrasted with superficial reports. This study strove to provide substantial background information for the data themes with the intent of offering a more thorough view to see how the findings might compare with other contexts.

*Dependability and confirmability.* Techniques for establishing dependability and confirmability include (1) audits, (2) triangulation of data sources and analysts, and (3) reflexivity (Lincoln and Guba, 1985). As a means of auditing, the primary researcher had provided this manuscript to two academic colleagues, who were not part of the project either as participants or the dissertation committee, for their input and review as a means to independently audit the project in its entirety. This study's key thematic constructs were developed independently by the primary researcher. In order to ensure against bias, and increase the rigor of the results, other analysts were independently involved. As discussed above, two members of the dissertation committee and three traditional Onʻyoteʻa ká community members also independently conducted thematic analyses.

As a means of triangulating analysts, themes and subthemes identified by the academic and community analysts were reviewed by the primary investigator and compared with his findings. Additional data identified by the analysts were recorded and

placed within thematic categories so that none of the data identified by any of the reviewers were discarded. An iterative process was undertaken to ensure that all themes and subthemes identified were in agreement across reviewers. A final meeting with one of the dissertation committee members was conducted to review thematic decisions. This review was instrumental in finalizing the main themes around symptom and health constructs, symptom impacts, and treatment factors that appear in the results, as that committee member has insider status to the Native American Indian community. All emergent themes appear in the results, and their related categories and subcategories were arrived at upon further examination by the primary researcher, the dissertation committee member, the community consultants, all meeting one-on-one with the primary researcher, as well as input from the participants.

As a means of triangulating data sources, this project gathered interview data from traditional Onʼayoteʼa·ká people involved with healing. Some of those interviewed hold titles of responsibility, such as Chief or Faithkeeper, within the Nation, others have some college education and they all had various levels of ability with the Onʼayoteʼa·ká language. Additionally, some of the participants were raised in more of a traditional setting than others. These cases represented multiple data sources that established a more comprehensive perspective on the research aims of this project than if data had been collected from only one type of case. The primary researcher sought to maintain a reflexive perspective by maintaining contact with friends, family, and traditional Onʼayoteʼa·ká community members to discuss potential biases related to the project. In addition, the project was discussed with academic colleagues when opportunities arose.



*Researcher reciprocity.* The concept of giving back more than one takes is consistent with Native American Indian worldview in general and is also being found with models such as Community-Based Participatory Research (Minkler & Wallerstein, 2008). Likewise, this is consistent with Onʌyoteʔa·ká traditions. The findings of this study have been shared with both the original interviewees and traditional Onʌyoteʔa·ká community assistants. In addition, the findings will be presented to the Cultural Wellness Center and the Oneida Behavior Health Department with the intent of increasing understanding of the traditional system to improve services for the Oneida community when this project is complete. In addition, the principal investigator will remain committed to the goals of this project for as long as the Onʌyoteʔa·ká community wishes including continued interpretation for application and mentoring of others. Within the Onʌyoteʔa·ká belief system, this is a more culturally congruent and valuable reward than some type of payment.

#### *Summary of Analysis*

This study utilized a process of data collection and analysis that allowed for the ongoing scrutiny of results. All data received were transcribed and coded independently by the primary researcher. Coding involved identifying constructs consistent with the DSM as well as emerging Onʌyoteʔa·ká-specific themes in the data. Ongoing collaboration and feedback was sought with the two members of the dissertation committee and the three traditional Onʌyoteʔa·ká community consultants. A meeting was held between the primary researcher and each consultant to examine and agree on the coded data. Coming to agreement is fundamental to Onʌyoteʔa·ká culture and governance. Member checking was also utilized throughout the analysis process. Thus,

the study's rigor and merit is fortified by these additional layers of analysis, and taking data, analyses, interpretations and conclusions back to participants for feedback. The final interpretation was then solidified by the primary researcher's status as an insider-academic. This study's interdisciplinary and collaborative approach strengthened the analysis and trustworthiness of the findings.

Three main domains were revealed; one having to do with illness constructs, another with treatment factors, the third with community impacts. The illness constructs domain demonstrated three clear categories including epidemiology, personal and relational factors. The treatment factors domain included inter-relational factors. The community impacts domain included ideas around balance and relating.

The results and interpretation will provide a description focusing on how the traditional Onlayote'a'ká culture conceptualizes and treats symptoms consistent with DSM depression and views general mental health problems. Furthermore, special attention was paid to (1) whether the traditional Onlayote'a'ká culture acknowledges a disorder that would be labeled "major depression" by the psychiatric system encapsulated in the DSM-IV-TR, and (2) if it does, what their conceptualizations are about possible causes, course, expected outcomes and treatment.

## CHAPTER 4.

### Results

Extended case method was used to collect interview data from seven participants who were involved with traditional Onlayote'a'ká culture, health, and language. The semi-structured individual interviews followed the reading of a vignette of a woman presenting with symptoms consistent with a DSM diagnosis of major depression. A thematic analysis was conducted including conducting multiple iterations to arrive at the final set of themes. Data collection and analysis was conducted according to the method proposed above. The participants indicated that they had helped people with similar complaints to the woman in the vignette. They also indicated that they found the interview questions interesting even though they found them to be confusing at times. First constructs from Onlayote'a'ká worldview and Western DSM-based psychology will be reviewed, then the results of the current analysis will be presented.

#### *A Priori Constructs*

Constructs from Onlayote'a'ká worldview discussed previously, included emphasizing the role community plays in health problems as symptoms affect more than just the individual. This worldview holds that individuals are intertwined with family, community and all of creation including spirits and spirituality. Core cultural tenets include compassion, gratitude and balance. Healing is often conducted in a ceremonial fashion with at least family present depending on the scope of the ceremony. In addition, specific medicine societies are used where a number of people come together to conduct healing in an interactive group format.

Constructs from the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR/DSM) include the four areas of cognition, affect, behaviors, and somatic. In addition, cognitions and behavior, interpersonal relationships (deficits, conflict, role disputes, and grief), and the neurochemical functioning of the brain are considered. The DSM, like Native American Indian constructs, considers personal and interpersonal functioning.

### *Main Themes Emerging From Analysis*

The analysis of these current data generated a description of traditional Onlayote'a'ká constructs involved with health and healing. In addition, a description of their conceptualization of symptoms consistent with the Western-based mental health diagnostic category of depression emerged. Analysis revealed the three main themes of (1) Symptom and Health Constructs, (2) Symptom Impacts, and (3) Treatment Factors.

### *Symptom and Health Constructs*

The theme of symptom and health constructs was purposefully incorporated into the interview. The interview included questions about whether or not what the woman in the vignette was coming in for was considered a problem, and whether it seemed to be an illness. In the Western system it is clear that the symptoms would be diagnosed as the mental illness, major depressive disorder.

The theme of symptoms and health constructs includes defining what the problem portrayed in the vignette is and what some possible causes are. In addition, themes around how the traditional Onlayote'a'ká conceptualization generally compares with the Western-based conceptualization, including healthy and unhealthy characteristics,

functioning, considerations of how someone might become unhealthy. Finally, the four domains of cognition, affect, behavior and somatic were specifically discussed.

The questions were designed to determine whether the traditional Onʼayoteʼa·ká system viewed someone’s symptoms in a manner that categorized them as aspects of mental health, whether there was a concept such as mood or, specifically, depression, and whether a common diagnostic label would be used. In addition, a question was asked about the cause of the symptoms in order to determine whether one would be specified and whether there would be a link between presumed cause and treatment. In the Western system, there is a fairly clear link between presumed cause and recommended treatment.

#### *Is There a Problem or Illness?*

There was consensus among the interviewees that the woman in the vignette was experiencing a problem. They indicated that this was obvious given that the woman in the vignette indicated that she was coming in to see what was wrong, and the assumption that someone coming into a place of healing likely wants help with a health problem. They noted, “*she’s obviously saying something’s not right*” (P3), and “*use her words...she said something’s not right*” (P2). However, all of the respondents indicated that the symptoms would not be considered an illness. The traditional Onʼayoteʼa·ká interviewed expressed discomfort about separating mental health from overall health, indicating that they would not take a categorical approach to the symptoms in the vignette.

The Onʼayoteʼa·ká language expert interviewed indicated that, while there are modifiers for “*mild, moderate and very much of something,*” the language does not have

terms that would be used to describe someone having a problem with mood that would classify them as pathological, or deficient or dysfunctional in some way. The term indicating “*very much*” would not equate to a meaning of “*severe*,” and there would be no vocabulary that would indicate a severe level in the Onʼayoteʼa·ká language. When questioned further about comparisons with the DSM, the language expert interviewee indicated that the Onʼayoteʼa·ká language does not use terms that would translate into concepts of remission or a distinction between short- and long-term. It was noted that the diagnostic label depression is considered a noun in English, whereas most concepts are expressed as a verb in the Onʼayoteʼa·ká language indicating that it would be thought of as an action, state of being or process, or in a relational manner. The interviewee suggested that the symptoms and treatment may be considered along the lines of a process of becoming into a state of being. This suggests that the traditional Onʼayoteʼa·ká cultural and healing system is situated to understand symptoms that the Western system views as mental illness in a different manner.

#### *Not Separating Mental Health From Overall Health*

All of the participants expressed discomfort when attempting to separate mental health from overall health, and while they each did a nice job of answering the questions about mental health, they often noted that it was very difficult to think in terms of making that separation. Participant 3 summed this sentiment up with these statements: “*I just really struggle with just isolating the mental part,*” and “*...it's real difficult for me to just focus everything on just that part of being human.*” At some point during the interviews all but two of the interviewees indicated that they did not view health in a manner that was separated into distinct domain categories. The other participants, P1 and P2, never

specifically addressed any aspect of separating health from other health domains throughout the interview. Instead, there was a focus on the interplay of all dimensions of overall health.

### *Diagnostic Label*

As stated above, analysis of the participants' interview data revealed that a person seeking help from someone involved with traditional Onʼayoteʼa·ká healing and presenting with symptoms consistent with a diagnosis of Major Depressive Disorder would be identified as having a problem. Despite the symptoms being identified as a problem the participants indicated that labeling the problem was much less important than determining the cause, which, it was noted, was needed to determine resolution.

None of the interviewees offered a label for the problem, and they seemed quite reluctant even when pressed. Three participants indicated that labeling a problem was something they would never do and so there was no use for giving a name to the symptoms. One noted, *“I try not to label or name specific things, specific diagnoses”* (P3). The interviewees further indicated that whatever term the woman seeking help used was what would be used. They stated, for example, *“I would call it whatever they want to call it...and get their definition as to what that is”* (P3), *“I would...ask her to define”* (P5), and *“I’d ask her what she would call it. See what she thinks about that”* (P4).

When specifically asked what they would call it, four Onʼayoteʼa·ká language interviewees provided a term to indicate a general way to describe what the problem was. The interviewees did not spontaneously provide this term and may have done so in an effort to appease the primary researcher. The term provided was, *“Yakonikuhlya·ksʼ”*

and conveys the general idea that the woman's mind and spirit are no longer operating the way they once were. This word can be translated in different ways depending on what the speaker was meaning to convey. The most literal translation equates to her having a "*broken or bad mind*" (P7). However, the interviewees that used this word provided a variety of translations. One spoke of her having "*exhausted all effort of going further*" (P1), while another discussed the term's use within the context of grieving and explained the use of the word as "*being cut-off from her mind and spirit*" (P6). That same interviewee added that word also meant that she was "*sad*" and that her "*mind and spirit was going along in a negative way*" that caused her to be "*out of balance.*" "Agyonigohogo" was a word offered by another interviewee and was intended to mean that "*Her mind is scattered*" like "*a thousand little thoughts all spread out on the ground*" so that her "*thoughts are incomplete*" and "*that she can't put them together to form a thought*" (P2).

The example above demonstrates the lack of heuristic value of, and the difficulty with using one Onʌyoteʔa·ká word to describe a condition because different people can use the same word to mean different things depending on their context and understanding of a situation. In addition, as described earlier, symptoms and problems are not separated out according to dividing health into mental and physical or mind and spirit problems into various types of categories such as mood. Coupled with traditional practitioners' refusal to label the reasons someone would come to see them, the analysis clearly suggests that a diagnostic label resembling depression would not hold heuristic value for traditional Onʌyoteʔa·ká people.



### *What Caused the Symptoms?*

The interviewees indicated that, despite insufficient information to be specific to the vignette, the symptoms generally could be viewed as having difficulty due to personal and/or relational factors. In addition, none of the respondents wanted to focus on mental illness aspects as being separate from overall health and they did not want to separate the connectedness of the mind and the body. However, it appeared that they tried to do that for the purposes of this interview.

*Need for more assessment to determine the cause.* The participants all indicated that they did not have enough information to make a specific determination about the cause of the symptoms. Some laughed at the lack of information (P3, P5, P6). Another participant expressed frustration and stated, “*There’s no substance here [referring to the vignette]...you can’t really make a determination whether where the cause is. I would need more information*” (P6). Other participants made similar calls for more information about the woman’s history and circumstances: “*she hasn’t said anything specific [about what the problem is]*” (P2), and “*...she has a problem not really labeled per se, but you need to follow that up...there is a cause but we don’t really know what that is*” (P3). The transcripts likewise clearly suggested that a thorough assessment of her whole life would be the beginning of the healing process in order to understand her within the context of the community and social surroundings. Interviewees indicated that they would need to have the woman “*talk*” and “*provide more information*” (P6) about why she was symptomatic.

The transcripts contained a lot of information related to potential causes of the women’s presentation. Some possible causes were provided, including “*loss of*

*direction*” (P2), and “*a disruption of her fire or something that’s going on with that*” (P4). Other participants indicated possible causes, but were quick to note that they were not sure about their guesses. One indicated that there was “*evidence of detachment,*” but also stated, “*where’s this detachment coming from?*” (P5). Another participant stressed the importance of determining the cause in order to engage in healing and stated, “*It seems like depending on which area would be identified as causing things would be the path that she would take up*” (P1).

A holistic assessment was called for by several of the interviewees, to determine the cause. This included a “*medical and spiritual assessment,*” a “*complete physical,*” and an assessment of “*her connection with parents, family and community support system*” (P5). It was stressed that the assessment would need to “*...look at her relationships with others*” (P3), and that it would need to be comprehensive. Participant 6 was most explicit, calling for a “*Whole assessment of their whole life and looking at all the conflicts that’s going on inside that person and finding some resolution to that. ...everything physically, emotionally, mentally, spiritually. ...her history, right from her earliest memory, what her life was like, her relationships were like and it depends on the background of her and if she has a cultural background or no connection to culture at all.*”

Further analysis indicated that this assessment would provide necessary information about the woman’s overall health, including spirituality, and the healthiness of relationships and connections with the culture and community. That is, analysis of the data revealed, themes around personal and relational, loss, and spiritual factors are

explored when the traditional Onlayote?a'ká respondents considered people who come to them for assistance.

*Personal and relational factors.* A clear emergent theme from analysis of the interviews was that a person is responsible for their physical health. Poor physical health, including neglecting a healthy diet, may lead someone to have symptoms. It was commented that *“as far as the body...putting stuff in there that’s going to even affect your emotions or not putting anything in you’re not feeding your body at all...so you want to start getting the nutrients in there so that all your processes can start running your brain can start functioning again,”* indicating that a *“poor diet”* will not provide the *“building blocks”* for good health (P3). Eating the proper foods was discussed and participant 4 stated, *“If I’m not eating properly my brain’s not able to function properly it’s going to affect my thoughts and my feelings.”* In addition, each person should *“eat them berries, blackberries and blueberries, and strawberries”* (P4), because berries are known to be foods that strengthen a person’s body and spirit. Using substances has a negative effect and *“it could be drugs and alcohol”* (P4) that caused the problems. In addition to diet and possible substance use, her physical health was also mentioned as there was consideration that she may be *“going through her change” (menopause)* (P1 & P5). Good physical health, including a good diet, was found to be the foundation for the mind to operate properly.

The study participants indicated that primary among the personal factors was taking care of the mind and thinking. As discussed in the diagnostic label section above, one’s thoughts are what sustain connectedness with the world around them. Each person is responsible for maintaining his or her mind and relationships with everything in

creation. Not working to have a strong mind may cause problems. The power and influence of suggestion was mentioned by Participant 1, "*Suggestion that someone is doing bad medicine upon them,*" and that the woman would need to "*strengthen her mind*" in order to overcome that.

Additionally, each person is responsible for being able to engage in healthy relationship, or to engage in relationships in a healthy manner. A good relationship with one's self and one's spirit is foundational for being able to enter into other relationships. These include relationships with one's self, immediate and extended family, one's clan, the community at large, the Nation and Confederacy, spiritual helpers, the physical world and all of creation. One participant concluded that the most important relationship was the one with one's self. This consisted of listening to the inner voice that tells right from wrong and leads one into the direction of life that's intended. Also, this relationship is about trusting one's self. Once this relationship is established and maintained other relationships can be fostered.

- *most important one is the one you have with yourself if you don't have that then you don't, you can't have respect for anything else around you so you have to have that very intimate relationship with yourself first and when you do it just transcend then outward to the family, to your clan, your Nation, the world, the universe (P6)*
- *one of the keys, one of the real basic principles or foundations of a healthy outlook on life has to do with listening to your spirit. Developing that relationship with your spirit. ...and so as we continue to just to not to listen we're going to continue to live a life where there's going to be constant consequences and so it it's real important that we develop that ability to listen to our spirit, to what we need to do to maintain balance (P6)*

Engaging with community and cultural events was also considered a personal commitment to relationships. This included maintaining a connection to others in the

community, especially those that were supportive, because she *“should be getting something from them that maintains her emotional and inner strength” (P5)*. Whereas entering into abusive relationships, including *“domestic violence” or “any of the abuses (sexual, physical, emotional, psychological)” (P4)*, was seen as detrimental and possibly causing symptoms. It was indicated that it was usual for people to attend community and cultural events, and that the woman’s symptoms may be caused by *“her connection that she normally would have with the people in her family is not there for her (P5)*. It was noted that someone who is unhealthy is *“someone who creates avoidance and isolates themselves” (P1)*.

It was indicated that an individual is responsible for ensuring that they are able to balance their life’s demands and continue to have fun. Problems may arise when if the woman in the vignette was unsuccessful with *“trying to balance a family life and a work life and a social life in and...[with her] own interests (P3)*. This may lead to *“difficulty at home with spouse, children, at work (P4)*, thereby pervading her life. The inability to maintain balance in one’s life can lead to the emptiness described in the vignette as noted by participant 4, *“she’s talking about ‘I feel empty’, something’s missing, well of course fun is missing because there is none of it.”*

Participant 3 discussed attempts to fill the emptiness in this way:

- *It seems like she’s very lonely and she’s looking for someone and she’s going through a process of searching and maybe really looking to herself to find out who she is and what she’s about and looking for some encouragement or support. ...trying to balance a family life and a work life and a social life and her own interests...well maybe there’s more to life than that*

This indicates that even though relationships and connections with others are extremely important, there are other things in life that need attention.

Balancing the connections with all things was discussed. It was noted, “*Balance is not like a teeter-totter,*” rather “*it is rhythm intertwined to some degree*” (P3). The intertwined nature was described as creating balance within each area of life while also at the same time maintaining balance among the relationships in life.

Several participants noted that viewing the mind, physical health and relationships in the manner described above was natural in historical times. It was noted that in modern times that view could be more difficult to practice. Participant 3 suggested that the symptoms could be because the woman’s view “*lacks cultural foundations*” due to her “*not raised in the culture.*” For the symptomatic woman it appears that the “*foundation of culture as basically love and caring for each other wasn’t clearly set*” (P2). It was noted that in the past families and the community existed in a manner where children were encouraged and raised in an approach that fostered their personal relationship based on cultural values. However, it was noted that in modern times there is not much emphasis on developing that serene relationship with one’s self so other relationship development becomes challenging.

- *It starts with the family because if you’re a family and you’re a tight family you’re caring for each other there’s really no reason to go outside to ask somebody what should I do because you have that strong connection with your family and your family’s the one who is helping you...they’ll lead you in that direction...to me the causes of this is the family unity (P2)*

The areas of personal and relational spiritual factors overlap to a large degree. As noted above, the study participants preferred to view all health constructs as being interconnected, but attempted to respond to the primary investigator’s interview questions. The interviewees did identify things that the woman in the vignette should attend to personally. However, many of the things identified as causing the problem dealt

more with relationships with other people, the community and ceremonies, and/or the spiritual realm. It was also noted that the woman might be having a difficult time balancing the multiple demands on her time.

*Factors of personal loss.* Several interviewees (P1, P2, P4, P5, P6) mentioned deaths and grief as being possible causes of the symptoms. It seems that this may be a separate category not specifically explored in this study, but it has been interpreted as another example of the importance of relationships and their disruption. The traditional Onlayote?a'ká system has specific and prescribed manners to deal with death and grief. These ceremonies conducted at the time of death and also annually for remembrance always include the community. In addition, unresolved grief and/or ceremonies that were not conducted in the manner that they should have been were implicated as possible spiritual causes of the symptoms. The statement by participant P4 demonstrated the consideration of grieving over death or other losses one may experience, *"It could be grief, maybe she lost somebody or something."* The others who discussed death-referenced ceremonies that are conducted when someone dies in order to restore the grieving people's minds.

This was evident also when the participants discussed the value of ceremonies that were necessary around deaths and the ability to complete one at a later time if the deceased are causing symptoms. Participant 1 recommended that the woman *"should see someone that has ability of clairvoyance"* and perhaps she would *"have to belong to any of the [medicine] societies."* Participant 3 noted that *"after people pass away and they come to visit they just want to make sure you know they're OK and make sure you're OK and once you acknowledge that and they can see that then it just stops or in some cases*

*they need to use ceremony to handle the situation,"* and reminded that *"from a cultural perspective that's nothing wrong...that's our normal."* Related to needing a ceremony for someone who had died, this indication could come in the form of a dream or from a seer as noted above. It would be important *"to see if anything has been done for that particular relative when they passed"* and to conduct a ceremony *"to appease the spirit of that person"* (P1). Participant 5 talked about the connection of everyday life and the ceremonial noting, *"family rituals are spiritual rituals."*

*Spiritual factors.* The idea of spirit was discussed in two main ways including personal and interpersonal spirits and matters involving spiritual entities. Personal and interpersonal spirits were commonly referred to as fires, which is useful as a metaphor to indicate how well someone's relationship with themselves and others is or was. A fire could be seen as having varying strengths. For example, an individual's fire could be roaring, burning nicely, at the point of embers, or barely lit or scattered. It was noted that when a person's fire was low it needed to be built back up again. Likewise, fires on an inter-relational level needed to be maintained to ensure they were burning with sufficient strength to be healthy and sustained. The logs of a fire include such things as *"caring and compassion," "awareness of the here and now," "being present and attending,"* and *"positive relationships, clear-mindedness, and balance"* (P3, P4, P5).

Having a strong fire involves awareness and clear-mindedness. Participants P2 and P1 spent time describing how the mind is the same as the spirit; that it captures the spirit in some way, and that the two cannot be separated. The mind, culture and spirit are so interwoven that thinking was equated to a spiritual process and that it is the power of the mind that captures the spirit.



- *Thoughts [are] very important to that because that's where it starts basically that's the root of wellness. ...our thoughts are connected to our spirituality (P2)*

The personal and interpersonal spirit was credited with being expressed in all things and as the entity that makes all domains “*kind of tied together*” (P4). It was stated that the spirit provides the connection to all things while the mind provides the awareness of how that connection proceeds. In addition, spirituality was discussed in different ways as being necessary to bring balance to the other areas and as a means to bind or tie the domains of cognition, affect, behaviors, and somatization together. Likewise, the “*other areas also help to aid in bringing back balance to the mind...they're all tied together in some way*” (P3). Another participant was most explicit:

- *The spirit ties all those other areas together. It's about the empowerment of the human being in a very good way. Kanikuhliyo, which is the power of the good mind that's what captures that expression of spirit. ...spiritual wellness is really about experiencing and expressing love and being connected internally with yourself or [externally] with your family and your community (P5)*

Spirit was also discussed within the context of spiritual helpers that are around and available to assist with matters of health. This requires a belief in something referred to as the unseen, and includes spiritual forces that cannot generally be seen by most people. “*The unseen is where we bring in a lot of the spirituality and a lot of the cultural perspective...like our medicine societies*” (P3). That participant indicated that it is “*important to start developing people's see and what we would call abstract and their own intuition*” (sic) (P3) in order for individuals to get more in touch with the spiritual realm. It was noted that there are some people who have a gift to see and work with these spiritual forces and provide assistance with health. These gifted people have the “*ability of clairvoyancey,*” and can “*see into that [health problems]*” (P1). These seers can be

sought out to determine if there is a spiritual cause of the symptoms and/or if certain spirits can help alleviate the symptoms.

- *Seek those people that are gifted as seers to have a look and see if that's something that we need in our life to for us to feel more complete or whole (P6)*
- *...get a reading done and that's what we would consider unseen. ...sometimes people will go and get a reading done and they'll end up belonging to a medicine society and then their symptoms are gone (P3)*

Again, like with personal spirit, the interwoven relationship with spiritual helpers needs to be fostered and maintained. If those connections, or fires, get low they needed to be rebuilt.

- *...then the unseen also kind of starts getting into the energy work. Culturally we talk about fire, well fire is energy and so it's kind of using more today's terminology to explain an older terminology and so that's where Reiki comes in and energy work and that comes into play and doing healing through that and restoring...looking at somebody's energy field to see where there's disruptions in it and starting to bring the balance back to that area (P3)*

Dreams were mentioned by one participant as another way to determine if someone needed to have a ceremony done or whether they needed to be involved with one of the medicine societies. Indeed, Participant 1 stated that dreams had a primary in understanding the problem: *"My immediate response is, what kind of dreams has she been having."* Participant 1 differentiated between usual and *"weird"* dreams that may indicate a ceremony for someone who was deceased, especially if it was about a *"relative"* or membership in a medicine society (the latter because, *"Dreams indicating a medicine society or death feast, that needs to be taken care of properly"*).

In summary, analysis of the transcripts revealed that the participants were not willing to label the problem represented by the symptoms. In addition, they had clear

response that causes involved relationships and spirituality, which are intertwined to the point that they can be considered the same.

### *Characteristics of Health and Unhealth*

In addition to interview questions about the vignette directed toward an exploration of Western-diagnosed major depressive disorder, several interview questions were asked to assist with understanding how the traditional Onʼayoteʼa·ká view mental health and illness in general and making a comparison to Western psychology. Questions were asked about the general characteristics of someone who would be mentally healthy and mentally unhealthy, whether these characteristics included consideration of deficits, functioning and dysfunction, and the areas of cognition, affect, somatic and behavior. Finally two questions were asked about how one would become unhealthy and how one could become healthy again after becoming unhealthy.

*Healthy.* The participants' responses to the request to define health varied quite a bit. There was some focus on the healthy side of feeling free and being at ease with one's self with Participant 6 indicating that someone healthy would have *"high self esteem, feel good about themselves and who they are."* They would also have an *"optimistic approach or view on life."* Participant 2 similarly noted that a mentally healthy individual would be *"somebody who can laugh at any situation and look at any situation and find something good."* They would also be *"somebody who can be compassionate and caring and give of themselves at any given time...unconditionally,* and have the capacity to *"forgive."* Participant 5 also spoke briefly about needing to be able to *"forgive"* in order to be healthy, and forgiveness being a *"spiritual process."* Participant 3 talked about needing to *"understand the benefits of all the emotions* and knowing how

to use them when needed." That interviewee also discussed the need to *"realize that life is going to have ups and downs"* and that *"they're necessary to keep us human and to keep us compassionate and to keep us in balance."* Participant 4 indicated that someone who was healthy would be noticeable because it would *"affect their body language,"* while Participant 1 indicated that someone healthy would be engaged in usual community events and be a *"person with no issues of any kind."*

*Unhealthy.* In contrast to the wide variety of conceptions of health, several factors were identified when general questions about unhealthiness were asked. The importance of disconnections caused by historical external forces was a central observation. The general negative impacts of European contact and colonization were discussed.

*"European behavior patterns, people appear to be detached, feeling alone, isolating yourself, feeling of abandonment, obsessive compulsive use of everything"* (P5). These foreign behavior patterns, ways of thinking, and over use of substances and resources have lead to unhealthy behaviors including isolation that creates a separation from community resources. This in turn leads to, *"somebody who has a little bit of support,"* and results in *"somebody whose self-esteem is very low"* (P2). The effects of contact and ongoing colonization has resulted in an *"ignorance"* of traditional culture and a biased view of world history, because the people do not fully understand *"the real [US] history"* (P6). This same participant indicated these conditions create *"unhealthy thinking"* and a *"a distorted view on life."*

It was noted that contact and colonization, and the subsequent pressure on the culture and disconnect of the community, have been traumatic for the people. This trauma has a clearly negative impact on the ability to maintain a strong mind, which has

resulted in many people having “*scattered thoughts,*” and an “*unhealthy mind*” (P4).

As noted earlier an individual will not be able to engage with others, including spiritual helpers, if they are not able to have a healthy relationship with themselves and this begins with having a good and clear mind. The traumatic disruptions brought by contact have created problems with the mind-spirit connection, and this trauma builds upon itself both through ongoing colonization and being disconnected from traditional community and cultural strengths.

- *When I think about mentally unhealthy I automatically see the spirit, because if it's intact and it's strong and it's being fed then I don't see the mental part; it will be in its place so to speak (P3)*
- *Current trauma usually triggers historic trauma and we see that over and over again in a lot of the cases because we're dealing with very dysfunctional family histories...ongoing ethnostress in our communities...people are not happy being who they are (P5)*

### *Functioning*

There was some initial confusion expressed by several participants about the Western DSM-based concept of functioning fully, as the interview question indicated. Participant 3 stated that everyone is “*functioning at some degree regardless...varying degrees of functionality is based on the societal belief.*” Interviewees generally indicated that a healthy person would be “*fully functional in what their involved in, of course they're not going to be fully functional [in all areas] ...functional, capable, reliable*” (P4). This was further explained by noting that no one was expected to excel in all conceivable areas of life and that a healthy person would be able to maintain “*good relationships with family and friends.*” They would be able to “*move around in these different situations and be comfortable, they can find peace in anything they do, feel*

*confident, not worried about what people are thinking about them, not worried about their self-esteem” (P2).*

A healthy person would be “[*fully functional*] within their own capacity (P5), which includes entering positive relationships and maintaining their roles and responsibilities of being a good human being and providing useful community work with whatever strengths and gifts that individual was given.

One interviewee indicated that functioning fully within one's capacity began with a good relationship with one's self and was "*the ultimate goal.*" They further indicated that someone can become less "*dependent*" on others and learn to "*be more internal*" by following "*what your spirit and heart's telling you*" (P6). In addition, interviewee Participant 1 indicated that a healthy individual would be functioning fully, and if they were not they would "*seek someone out to help them with their situation.*"

### *Deficits and Dysfunction*

Interview questions about deficits and dysfunction, which were also incorporated to reflect DSM concepts, were also explored. As with the concept of “functioning,” all of the participants expressed having a difficult time understanding the word “deficits” within the Onʌyoteʔa·ká culture and language. In fact most of the interviewees laughed at those words and indicated that they did not think in terms of deficits and dysfunction. Some responses to the questions included: “*I don’t have that terminology in my thinking*” (P4), “*I’m having a hard time thinking of it that way*” (P5), and “*I’m still confused about that deficit*” (P6).

However, one participant indicated that sometimes it becomes apparent that someone has an area of functioning in need of improvement and that becoming aware of this should be seen as an opportunity or a reminder of an area needing growth. That is, it would not be viewed in a negative manner. That participant elaborated by explaining that *"To me dysfunctions means something's not functioning the way it should be, and that's not going to make you a well person" (P3).*

Analysis of the other interview data concerning the idea of dysfunction yielded similar results. Most of the respondents expressed that they did not think in terms of dysfunction, leaving one to laugh and question, *"How can someone function unfunctionally?"* Everyone *"always functions to some degree" (P3).* Participant 4 agreed and noted, *"It would probably vary with some people to a different degree they're able to function."* Another participant noted that at times different people might appear to be less functional. However, unless that was a continuous *"negative response to the world"* and a clear problem with being in *"the here and now,"* it would not necessarily be viewed in a negative manner as a *"very different way of relating to the world and that could be presumed to be deficits...so I don't know whether they're deficits or not."* That participant further indicated that they thought the question about deficits and dysfunction was *"a trick question" (P5).*

#### *How One May Become Unhealthy*

There were questions asked about becoming unhealthy and regaining health in this general section. Responses focused on the more recent historical times of post-European contact, and it was noted *"started when our people started to encounter the non-Native people" (P2).* The systematic devaluation and intentional destruction of the

culture, corresponding with soul wound, was credited with creating a general unhealthiness that provided for further unhealthiness to continue. Participant 3 indicated that an individual must have their personal needs met in order to be healthy and stated, *“In a nutshell it’s any of these [eight basic human needs] are not met then I think that’s an opportunity for that [unhealthiness] to happen.”*

“Various scenarios” such as “loss of job, loss of family member, separated” (P1), and “all kinds of ways” including “death, marriage break up, loss of a loved one, spiritually abused” (P5) were identified as paths to becoming unhealthy. “*Alcohol, drug,*” (P2) and other abuses, including childhood trauma, were also identified as ways of becoming unhealthy. The participants stated: *“it could be drugs and alcohol it could be their childhood, old childhood hurts, ...or current life situation abuses” (P4), “The majority of dysfunction begins in their childhood...dealing with very dysfunctional family histories” (P5), and “...go back to childhood and see where a lot of mental or emotional imbalances...stem from their childhood” (P6).*

Additionally, the effects that the loss of cultural values and strengths has had on individuals, including apathy towards connectedness and traditional self-care were identified as well. These effects result in *“Just not listening to yourself anymore and just doing what you want to do...you know not care. Alcoholism, destruction of families...”* (P6). Furthermore, it was noted that the Western education forced onto generations is counter to traditional Onʼayoteʼaʼká ways of gathering knowledge and values. Participant 2 stated, *“education being so wrong for our people”* (P2). Higher education was



included in this discussion and it was noted that when someone becomes educated they devalue and lose traditional cultural and spiritual beliefs.

### *Becoming Healthy Again*

Responses to questions about regaining health included finding ways to counter the ways someone may become unhealthy and to reengage cultural strengths. Participant 2 stated, *“It stems from the [traditional] society...programmed to love, there’s no anger, there’s no hostility, nothing there but the love because that’s what the community reflects, that’s what people reflect.”* It was also noted that there are people in the community who can provide assistance. If someone is unhealthy, a helper should *“get them to the right people, right resources, there’s always going to be people there to give them that reassurance and support to regain their once vibrant life” (P1)*. Spiritual helpers, who historically were a fixed part of the culture, were specifically talked about by Participant 6: *“In our culture there’s helpers that are there...believe in that versus it being like a fairy tale so you know there’s powers or spirits out there greater than us that can help us and that’s where we need to seek those people that are gifted as seers to have a look and see if that’s something that we need in our life for us to feel more complete or whole.”*

It was revealed by one of the community consultants that the foundational teachings of the culture provide lessons about how to regain health. This was discussed on follow up with Participant 1. This participant observed that the Great Law, which is one of the most influential foundations of the culture, not only teaches how to live but also teaches about compassion. The personal thanksgiving teaches gratitude and that The

Good Message provides rules for living life as intended and also teaches about the balance of positive and negative aspects of life.

Another participant indicated that some of the current generations might be lost and unable to regain traditionally healthy lives. That participant emphasized focusing on the newborns and young children in a manner that instills the cultural beliefs and values. This respondent indicated that this change must begin with families and parents and that perhaps a small group could begin to turn away from the Western influences and towards the traditional cultural strengths and ways.

- *I think starting with a single generation and putting all of these values and all of these beliefs instilling them in so that they feel really good, provide that atmosphere of love and caring, provide that atmosphere of sharing and helping each other out. It becomes instilled in those kids, I think that if a person wants to become well it has to start with that generation so when that baby's born it's there it's present right there and that baby grows up in and if there is enough families that stick close together and they're really sincere and they're really dedicated to that all those children are going to grow up that way all those children are going to grow with those values and I think that's where it has to start because when you take a generation I mean you can do it with adults but it's going to be kind of hard to me because of all these old ways that you just kind of every once in a while you fall back on but with the younger generation if it's instilled on them right from the time of birth...they see it all their lives it just becomes second nature to them (P2)*

Several participants noted that adults would need to confront the trauma created since contact with Europeans in order to regain health.

For example, Participant 5 indicated that adults could heal by,

- *facing their history, track the origin of their trauma of their original hurts, develop a process to correct those. ...requires a lot of spiritual work, forgive themselves, to forgive their perpetrators and forgive the history or those that didn't protect them, ...act of forgiveness that's required to find good mental health and that's really a spiritual process. Break the patterns that their anger inside them and once they achieve that they can come to a place of good mental health (P5).*

This would include an ongoing commitment to the change toward health; *“They got to want it...and it’s an ongoing thing for the rest of your life” (P6)*. A commitment to health would include an exploration and understanding of the history of colonization and the effects that has had on individuals, families and the community culminating in forgiveness on many levels.

Ultimately, responses about becoming healthy focused on the community rather than the individual, and they all emphasized the necessity of finding and maintaining balance within and among the many relationships of life. It was noted that people needed to concentrate on the relationships with their *“mind, body, heart, and spirit”* and continue *“trying to bring them into balance, closer to balance (P4)”* in order to *“feel their needs are being met, bring balance back to their mind, their body, spirit, heart*. This would *“rekindling their fire (P3)”*. Even when interview questions were about the health and healing of an individual, the responses always included considerations of relationships and balance with the rest of creation. Participants indicated that countering the effects of contact and education could be accomplished by utilizing community resources. This included getting back to traditional self-care, meeting one's basic personal needs, and maintaining balance. For example, Participant 6 discussed the importance of returning to a traditional diet as part of the strengths of the culture and revealed that the people have, *“...gotten away from our traditional foods for so many generations, food affects our emotional well-being, diabetes, I think that’s a really big, big, big part of reestablishing our healthy community.”*

In summary, general characteristics associated with being healthy and unhealthy were revealed. Responses to questions about being healthy included various means

having a positive approach to the world. This contrasted with being unhealthy, which focused on the effects of changes since the time of contact with Europeans. The concepts of functioning, dysfunction, and deficits appeared to be absent within the traditional Onʼayoteʼa·ká constructs. Considerations of how one might become unhealthy included scenarios where the people were separated from the cultural strengths. Responses to a question about becoming healthy again focused on repairing separations.

*The Four Domains: Cognitive, Affective, Behavioral, Somatic*

Interviewees were asked if they thought about mental health within the four domains of affect, somatization, behavior, and cognition. As described above, all of the participants indicated that they did not think of health in a manner that separates it into categories. They indicated, *“to be mentally healthy I would think it would include all of those”* (P3), that *“all four of them are really important,”* and that there is *“no separation of any of them”* (P2). However, they were able to answer specific interview questions about the four domains that are considered when assessing health, even though their conceptualization encompassed the balance within and across domains.

One practitioner indicated that many Onʼayoteʼa·ká people who present for services were *“not in touch with their feelings”* (P4). Affect or feelings was mentioned by two other interviewees as well. However, this was not brought up by the other participants. It was found, on interview specific with the language, that the Onʼayoteʼa·ká language does not have a set of vocabulary for affect and it is therefore not surprising that traditional people would not relate well about emotions. This suggests that the concept of affect likely has begun to be explored among some traditional Onʼayoteʼa·ká practitioners. It was suggested that the vocabulary indicating the state of mind and spirit

may be used to indicate how someone is doing with their quest for *oskʌʌshúha* (i.e., profound peacefulness) rather than affect (P1, P6, P7).

For the traditional Onʌyoteʔaʔká interviewees, the somatic domain appeared to include body language, maintaining good physical health, and ensuring that one ate healthy foods to ensure that the building blocks were in place for the other domains to be healthy. Body language was designated as something very obvious to some interviewees as an indicator of someone's wellness. Participants stated that wellness is easy to “*detect in the way they walk, the way they’re talking, just the way their body language...actions*” (P1), and that wellness can be seen because one can “*just read it in the body a lot of time*” (P3). When asked, none of the participants indicated that somatic complaints such as a stomachache or headache would indicate a mental health problem.

Behaviors were discussed by all the participants in relation to health. However, behaviors were always viewed as social functions and were understood within that context. For example, an indicator that something was likely wrong would be any change from “*usual*” or expected behaviors, or if someone was not attending community or ceremonial events. Behaviors outside of a social context were not discussed.

Analysis of the interviews revealed that cognitions were a primary consideration, as noted previously. The mind, thinking, and the spirit were equated as before. Participant 2 indicated that the goal of life is to attain “*oskʌʌshúha*,” or tranquility of the mind and spirit, or oneness of the mind and spirit. That participant also indicated that “*thoughts are our spirituality*” and “*thoughts are very important, you think of thoughts and that’s spiritual, that’s where it starts basically that’s the root of mental wellness,*

*your thoughts are going to dictate your body, your behaviors are affected by your thoughts, that's the stem of it."*

When considering the symptoms an individual may be experiencing, the participants did not report focusing specifically on any one of the domains. Rather, a problem was perceived in terms of one or more of those areas being out of balance and/or not having balance among the domains. It was noted, *"when you're looking at mental health to me that means whole, so in order for you to be mentally healthy you need to incorporate the other components"* (P3).

All of the interviewees described the four domains as being held together in some fashion. The concept of spirit was used, as Participant 6 stated: "

- *There's another component that's crucial that's the spiritual part. [The four domains] are all human, concrete type, but the spiritual part is of a different realm of being that I think is real important. There needs to be some form of a belief system in a higher power, driving force in their life. Some kind of belief in the higher power of the spiritual realm that they can always turn to for strength or guidance."*

The construct of spirit was used to describe how the other domains are connected and inseparable, for example:

- *They're all kind of tied together. [Add] spirit or fire...essential self what makes up that fire...them logs of kindness and consideration and compassion, those kinds of things (P4)*

Spirit was also considered as a possible fifth domain, for example:

- *[Add] the healthiness of the spirit of the person too. Whether it's a fifth area or whether it's something that ties all of those areas together. ...express a kindness and sense of being one with the world and understanding what that means like all of those being connected and also at the same time being very cognitive of how they touch the world there's a sense of spirituality, it's not about religion it's about the empowerment of the human begin in a very good way. Kanikuhliyo, which is power of the good mind that's what captures the spirit that expression of spirit of all four of those [areas] (P5)*

In summary, all of the interviewees indicated that the four domains of cognitive, affective, behavioral, and somatization were important. However, it was found that the concept of affect is absent from the Onʼayoteʼaʼká language and is therefore not a traditional construct. It was suggested that the term affect might be translated to indicate someone’s progress toward peacefulness. Additionally, the interviewees were more focused on describing how the domains were tied together by what they called spirit. Spirit was depicted as a force that holds the essence of life together.

#### *Summary of Symptom and Health Constructs*

Numerous symptom and health constructs were identified by analysis of the interviews. These themes were grouped under the headings of (1) defining the problem, (2) possible causes, and (3) a general comparison of Onʼayoteʼaʼká and Western concepts. Table 3 lists the main areas of symptom and health constructs discussed (see Table 3).

The respondents acknowledged that the woman in the vignette was experiencing a problem, however, they did not name or categorize it. In addition, the participants expressed difficulty responding to interview questions that asked them to separate mental health from overall health. This indicates that the traditional Onʼayoteʼaʼká participants did not view mental health or DSM mood disorders such as depression as distinct categories of illness. Rather, they viewed health holistically. Despite not using a label, the participants offered some possible terms to describe the woman’s condition when pressed. These terms tended to focus on the mind, but also included consideration for connections with the spirit as part of the same word. In fact, it was discovered that the

same word root is used to indicate mind or spirit. The idea of a mental illness labeled depression appeared to be a foreign concept.

Analysis of the themes around possible causes of the symptoms began by identifying a need for a holistic health assessment that included gathering personal history and history of relationships. Additionally, the assessment would include physical and spiritual aspects. Attention would also be given to determining whom the woman used for support in the community. There were methods of self-care that were identified that the woman in the vignette would be expected to engage in. There were also relational patterns with others in the community and within creation that the woman was expected to connect with and maintain. In addition, spiritual and ceremonial practices were identified that if neglected could lead to the symptoms. General possible causes of the symptoms included a lack cultural foundations, being out of balance, being isolated or not engaged with others and the community, having suffered from a disruption, disconnection or detachment within one or more relationships resulting in a loss of personal direction or feeling disempowered, and not having fun in life. In addition, the effects of contact and assimilative pressures, including substance abuse and childhood trauma, were suggested as well.

A general comparison was made by asking respondents questions about constructs used in Western mental health. The interviewees expressed confusion when asked about the terms deficit and dysfunction, indicating that those terms were foreign to their conceptualization. They tended to view each person as being able to function within their own capacity and indicated that no one was expected to be able to do all things for all people. One respondent wondered aloud if these were trick questions. It seemed to them



that an area of deficit could simply be a reminder that a person had an area that needed growth, and that perceived deficits could be used as a guide rather than seen in a negative manner. Considerable time was spent by the participants on describing health in a holistic manner, and they continually expressed discomfort with separating any of the domains.

A construct of spirit, fire, or spirituality was repeatedly uncovered when exploring the conceptualization of the description and possible causes of the problem presented in the vignette. This was described in various ways including as a level of personal and interpersonal strength and as a way to bind all of the domains of health together so that they were inseparable. Being unhealthy was described as being out of balance, whereas being healthy was described as maintaining balance within and among the domains of health and with relationships. Relationships were discussed broadly and included connecting with one's self, family, community, clan, Nation, and all of creation including spiritual forces. It was noted that a healthy relationship with one's self provided the foundation on which all other relationships would be built.

Table 3. Areas of Symptom and Health Constructs.

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What the problem is

How the problem is defined

Possible causes of the symptoms

Personal and Relational,

Loss, and

Spiritual factors

Traditional Onʼayoteʼaʼká compared with Western conceptualization

Healthy characteristics

Unhealthy characteristics

Four domains of:

Cognition

Affect

Behavior

Somatization

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### *Symptom Impacts*

#### *How Does the Problem Affect the Individual and the Community?*

The theme of symptom impacts was analyzed using the interview data pertaining to the questions about the implications for the community of an unhealthy individual compared with the impacts of a healthy person. Impacts of the symptoms both to the individual seeking help and the larger community were considered.

In the Western system, the impacts of depression are usually described in monetary terms including (1) direct treatment costs, (2) indirect economic costs arising from increased mortality rates, and (3) indirect economic burdens arising from productivity (Greenberg et al., 2003; Greenberg et al., 1993; Hirschfeld, 2000; Kessler, Barber, Birnbaum, Frank, Greenberg, Rose, Simon, & Wang, 1999; Ormel, VonKorff, Ustan, Pini, Korten, & Oldehinkel, 1994; Simon, 2003; Stewart, Ricci, Chee, Hahn, & Morganstein, 2003; Wang & Kessler, 2006). However, the traditional Onlayote'a'ká participants did not indicate any consideration of monetary costs.

Instead, analysis revealed two sub-themes. First, some interviewees provided a description of what the impacts would have been historically compared to modern times, and secondly others focused on personal and interpersonal functioning.

*Personal and interpersonal functioning.* Some of the participants discussed the impacts in terms of relationship disruptions. This included effects within the individual, within their immediate family, and throughout the Nation and creation.

It was noted that problems interfered with a person's relationship with themselves, which in turn made it impossible to engage in other relationships in a healthy manner. Participant 4 discussed healthiness as "...good mind *Kanikuhliyo Katsnaslasla*

*that fire or spirit that's within us and having that and using that Kunoukwasla that love that caring and all of that is contributing to that joy of being and when we have that within us then we're able to share that and model that"* and unhealthiness as lacking those same things.

Healthiness was discussed in terms of engaging in usual behaviors and being with family members and engaged in the community, *"...family is together; no immediate issues...people are just sort of hanging out"* (P1). Being able to help others was also specified for being healthy, including being *"able to provide for their family"* (P4). Recognizing when someone was having problems was discussed, whereas reengagement with family and community activities was noticed as an indicator that they were again doing well.

- *...if that person is a well known person then everybody will sort of know that something's going on with this person so they need to try to find those remedies again to take care of him or her (P1).*

There appeared to be consensus that negativity needed to be dealt with for the good of the community, and that if someone was *"dangering themselves or others then find someone that is respected to diffuse the situation [and] assist that person (P1).*

Unhealthy behaviors are *"going to have implications for the community it's just a matter of degrees, the community would need to address them and try to help them"* (P4). If the unhealthiness was not treated, then issues such as *"lack of education, unhealthy behaviors, [and] chemical abuse"* would *"become generational and it becomes acceptable behavior in this society"* (P6). The effects of healthy people were described in a similar manner, and the positive aspects and influences of the strengths of the traditional culture were implicated on an interpersonal level. For example, participant 5

stated that *“social entrepreneurs are doing good things and in a way directly or indirectly it’s benefiting other people and I think that’s a very powerful way of being in the world...that’s a good sign of good mental health. I think when you look at our traditions that’s what we’re supposed to be doing.”*

Positive and negative influences were discussed as being like throwing a pebble into a placid pond. The outgoing ripples were like the effects of an individual in all directions, impacting everything in his or her wake. The effects of an unhealthy person were described like the *“domino effect, ripples out, it’s going to affect you in an emotional way, which will affect your mental state. The difference is they usually kind of take on the same energy that person has in more of bringing them up instead of down”* (P3). Healthy and unhealthy individuals were described as having the same level of energy and impact, except they influence the community in different directions.

*Contrasts between historical and contemporary times.* It was indicated that historically the vast majority of the community would have been healthy because they would have all understood and lived the cultural values of being selfless and sharing, taking care of each other and working for the good of everyone. They would have sought to live in peace, harmony and balance with themselves, each other and all of creation. In historical times the impact of a single healthy or unhealthy individual would not have been much and the community would have been able to assist an unhealthy individual easily to help them get their mind back in order.

- *I guess a long time ago there wouldn’t be implications because their behaviors were programmed or how to behave in society but looking at today it would be a lot of implications because there’s a lot of cross-references kind of so to speak, Everybody’s train of thought was we need to survive we need to do this together whereas today it’s all individualized so nobody’s really taking any responsibility for group consensus. A long time ago you need to be careful you*

*need to look after one another, there's that love and there's that caring so where was the threat of somebody who wasn't mentally well there was no threat, but today ...how it was before because then everybody was focused on one way everybody was focused on survival everybody needed to get along there was all of that love and compassion so that person was surrounded that even if he wasn't mentally well he was surrounded by that and he learned that and that's who he was because it was programmed into him but now today there's nobody taking the time to do that so there's such a big difference between now and yesterday (P2)*

However, it was indicated that in modern times, more community members are focused on themselves and fewer people seek to adhere to the core cultural teachings.

The "...*unhealthy mental state of our community*" is a result of not *experiencing enough of our traditional values anymore and it changes the nature of our communities*" (P5).

Furthermore, the effects of contact and colonization were discussed as contributing to poor health.

- *These ailments don't stem from the culture, but there's prescriptions that can come from within the culture like within our medicine societies to put that person more in balance, culturally with ceremonies that we have we're acknowledging that and it's looked at...it's not something that's being covered, then there's a spirit that goes with that, that needs that recognition that needs that acknowledgement. If there's just a very small group or people that believe it then it's not going to transcend throughout the whole community (P6)*

It was noted that the number of people that follow traditional ways continues to decline, which makes it more difficult to have influence over negativity and poor health.

In modern times, then, the unhealthy individual creates a greater impact as others may also think that is the way to get what they want. Concern was expressed that unhealthiness would "*breed more unhealthiness*" and continue until it "*deteriorate[s] the whole Nation*" (P2). In addition, the same participant indicated that if the people continue to stray from the traditional culture, a time would come when the people's understanding got to the point where it was "*so far away from that original*

*understanding of what we're supposed to be doing it's going to be almost impossible to get back."*

The effects of modernity appeared to be connected with many of the people losing their personal connection with the strengths of the culture and no longer being able to find the path of life they were intended to be on. These effects allowed a building or snowballing space for negativity to grow, whereas the culture before contact maintained space for positive influences to grow. In modern times *"the negative feeds on the negative"* (P5).

#### *Summary of Symptom Impacts*

The differences of the impacts of healthy and unhealthy people were identified by the participants, as revealed in the analyses. Table 4 lists the main areas of symptom impacts (see Table 4).

A comparison was drawn between historical times, when more of the people lived according to the directions provided in the Onʼayoteʼa·ká culture, and more modern times, when the effects of contact with Europeans are seen. It was revealed that during historical times there would have been very few individuals who would have been considered unhealthy, because everyone strove to maintain similar thinking and worked to care for each other in a compassionate manner. However, it was discovered that these same interviewees experienced modern times as having far fewer people adhering to core cultural traditions, as many people have become interested in individual gain over community health. The effects of contact and colonization were identified by the participants as leading to poor health.

Relational disruptions were also frequently identified as outcomes of being unhealthy. It was noted that many people no longer maintain a healthy relationship with themselves and therefore find it very difficult to engage in healthy and balanced relationships with others. The participants also expressed concern that symptoms could cause individuals to isolate and neglect engaging with others and the community.

Table 4. Areas of Impact of Symptoms.

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Historical and contemporary times

Personal and interpersonal functioning

Impacts of illness

Individual

Family

Community

Creation

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### *Treatment Factors*

The interview included questions about treatment factors. The questions pertained to what the woman in the vignette should do about her symptoms, but also what someone else should do. Who else should be involved with treatment was asked, and there was a question about the expected course and outcome of treatment. Lastly, there was a question about how she and the person working with her would know that it was time to stop treatment.

Similar to the responses to interview questions about possible symptom causes, all of the participants wanted more information to determine what to do about the symptoms. They all expressed discomfort about guessing about the nature of the problem, it's cause and corresponding treatment. Participant 6 summed this sentiment by saying: *"Without more information you can't really form what the cause is and what to do."*

Despite the lack of information the participant's general responses included encouraging the woman to seek someone in the community out to assist her. She should *"...talk to someone else...provide more information about why she's feeling discouraged, sad, no appetite, feeling empty, hopeless, difficult at work" (P6)*. Also, it was noted, *"there are capable people that the person needs to be able to identify" (P1)* who can assist with the symptoms. All of those interviewed indicated that they had seen people with similar symptoms and would be willing to work with the woman. As noted previously, an assessment of her life to include relationships past and current, traditional medicine practices, dreams, diet, activities, and a physical would be conducted as a starting point. Treatment roles were identified both for the woman in the vignette herself and for others who could assist her.

### *Roles in Treatment*

The participants indicated that the symptomatic woman would need to be engaged in treatment and would be responsible for taking control of her own well-being. Nonetheless, they identified roles for others as well. While there were foci on roles for both the individual and others in the community, most of the work was collaborative and involved *“empowering work and getting the person to take their own well-being back into their own hands” (P3).*

*Her roles.* Interviewees identified some fundamental things that the woman herself should do. She should *“learn about it [the problem] and explore what’s going on with her so she can look at and learn about the possible causes” (P4),* and personally *“assess what she’s doing on a daily basis to strengthen herself” (P5).* It was found that she would also needed to be *“around more positive people who are going to lead her in a direction” (P2).* The participants also noted that the woman should take responsibility for seeking out others including *“connecting with her spiritual advisor” (P5),* and that she needed to *“find someone, who can meet on a regular basis, to help support her. Might be someone within her own family that already have been through one of the various scenarios...help each other” (P1).*

It was recommended that the woman engage in personal growth work and better develop her relationship with herself. As noted by Participant 6, that personal relationship is primary and everyone should begin *“listening to your spirit and developing that relationship with your spirit, developing a relationships with yourself.”* This personal work would help the symptomatic woman work with others as they assist her.

*Others' roles.* The participants expressed roles they, as healers, could fulfill during the course of treatment. It was expressed that anyone coming in for help would already have been known within the small traditional community, and that would set the stage for understanding issues involving the woman's interpersonal and inter-spiritual relationships, as well as her areas of personal strengths and those areas in need of growth. However, since the woman in the vignette was not known to the community, and the vignette provided only limited information, more general responses were provided.

Once the assessment was complete, the person working with her would likely begin with empowering work and *"would ask her what does she want to do about it...I would really explore it with her"* (P3). The woman would be placed in charge of her treatment and encouraged to *"provide more information to get more insight into where she's at and how she got there"* (P6). She would be encouraged to work on her connections with other people because those connections are *"things that empower the person, her being connected with her partner, being connected with her daughter, and her extended family. What is she not doing around that that's lessening her...that's taking away her ability to be connected?"* (P5).

Reminders and teachings about traditional cultural strengths would be provided as

Participant 3 noted:

- *I use a lot of stories in my work too. I listen to their stories and help them to find the meaning in their stories and then they also listen to my stories because I do my best to weave the culture into the whole process and so if I see this is an appropriate time to tell a story that might help them to see themselves then I'll tell them the story*

One participant indicated that someone working with her would need develop trust and provide her support so she could again engage in community events and begin to see the good things in life.

- *Somebody that she can build a trust with. Somebody she can build a bridge to bridge that gap because she's all by herself. She needs to trust that arm that's reaching out for her just lead her in the right direction and when she's able...that's how we say it, we'll dust you off and we'll support you, we'll carry you until you're able to do that by yourself and you can walk beside that person or you can start to go on your own road (P2)*

All of the participants indicated that in addition to themselves, there were others in the community would be able to assist her with her symptoms. These other persons ranged from a “relative” (P1), a “seer” (P3, P4, P6), whomever she “usually sought for spiritual guidance” (P5), or “anyone” (P2, P6) in the community who would be helpful. This referral process of “connecting her with other community resources” (P5) would have been facilitated by any of the interviewees. A spiritual seer, in addition to interacting with the unseen to determine the cause and treatment of the symptoms, would also assist the woman with “developing her see, her own intuition” (P3).

The community at large also has a role. For example, a ceremonial process to replace missing relationships through binding adoption or *friendship ceremonies* (P4) was discussed by participants. This is a process that would begin with “look[ing] at her relationships with others” to determine if the symptoms were being caused because of a need for a certain relationship or relationships. If that was the case then a ceremony would be done to “replace those [missing or lost relationships and] people because culturally we have a process of replacing them in the sense of not replacing them literally but figuratively so that our needs are still being met” (P3). The friendship ceremony is binding for life, so the process is not entered into lightly and is highly “selective” (P3).

This would be a mutual process where the adopter and adoptee would each act with the roles and responsibilities that relationship took on. For example, if the woman felt she was missing the importance of the relationship with her estranged brother she would seek out someone in the community to fulfill that brothering role and she in turn would fulfill the sister role for him.

In addition, it was noted that she might require the assistance of someone to help her with her diet and ensuring that she was eating healthy traditional foods. Participant 6 revealed, *“we’ve gotten away from our traditional foods for so many generations that our bodies aren’t breaking down these kinds of foods that we’re eating and that effects our emotional well-being” (P6)*. Traditional foods coupled with recommending *“vitamin supplements you know B complexes and probably the Omega-3s (P4)* would *“help to fuel that fire inside of her (P2)*.

#### *Course and Outcome*

The course of treatment expressed by the participants ranged from *“immediate once you identify [the cause] (P1)*, to something that a person would need to *“work on every day of your life” (P2)*. Within this range was the desire to continually monitor progress and beginning treatment with *“one month to start and then reassess. [probably] weekly meetings...taper off to one time a month” (P5)*. It was expressed that the course usually *“varies from individual to individual” (P3)* and would be up to the woman and would *“depend on what she’s willing to do”* and *“she’s got to want it” (P6)*. Participant 4 recognized that the symptoms may resolve and other needs may arise in the future and noted that a person *“can come back if needed” (P4)*.

All of the respondents indicated that they generally expected a positive outcome from treatment. The participants provided a range of expected outcomes including, *“the person would achieve what they’re looking achieve, developing the skills to take their well-being back into their own hands” (P3)* to the symptoms being *“not as intense as in the beginning” (P5)*. Participant 1 revealed that with *“discussion on a regular basis...She’ll be able to get back to the way she was in her life again (P1)*, while participant 2 stated, *“I don’t think I would ever predict an outcome. Our goal would be to find that peacefulness and be able to look again at life with love and beauty through everything,”* and attain *“skanotunyot, or peaceful thinking, and “skanotsikso, or a peacefulness of personal spirit or fire.”* That same participant related that a person would need to be committed to changing their life and making sure to *“fill it with things that make you happy.”*

#### *Protective and Risk Factors*

Participants’ responses to questions about protective and risk factors seemed to be two sides of a coin. They indicated that protective factors included engaging in cultural strengths and views, and that this was most easily accomplished by being *“raised in the culture (P3)*. However, one who was not could come to learn these fundamental views by understanding *“our [cultural] foundation is built on that peace and if a person doesn’t have that foundation every time they try to add onto something it’s...just going to sink... it’s not going to be stable, it’s not going to stay...it’s missing and that person isn’t going to be complete until that foundation is completely set” (P2)*. Participant 4 also expressed a need for culturally-based thinking and understanding.

- *Everything has a purpose and so what’s the purpose of sadness and what does that bring to us and trying to get them to flip the thinking*

*around and looking at it more positively and to encourage them then to look for the lessons in this...what's the lesson for this for me in this...getting them to look at that belief that everything happens for a reason*

- *There's a positive and negative with everything, that's another belief. What's the positive in this because then that's part of encouraging them to look at that and hopefully to inspire that hope...that it isn't going to last forever and that they can work through it and come out of it*

Engaging in anything that strengthens a person's sense of well-being was identified as a medicine and seen as protective. A medicine was defined as anything *“that is something we can get totally lost in. We lose track of time, our worries, and trauma and drama it all leaves and we're intently focused on... for example art is one of my medicines that I can use and pretty soon I'll look at my watch and it's two o'clock in the morning it's like oh I've got to get to bed I've got to get up in the morning so it's things like that that's a medicine it feeds us it feeds our spirit” (P4).* Continually and faithfully working on determining and fulfilling one's purpose in life was indicated as protective from symptoms. Participant 6 stated, *“we're all here for a purpose and in some way shape or form we affect other people hopefully in a good way but even negative experiences are a very powerful learning tools once you really go into it...you've got to have some kind of faith.”*

Participant 1 indicated that the woman in the vignette should engage in activities that would *“enrich her life or strengthen her mind.”* This would help her with fulfilling her purpose. A good diet consisting of traditional foods was mentioned because *“you can get all the nutrients you need in the foods you eat” (P3),* which in turn assists with having a fulfilled life. Participant 4 recognized that *“diet can be used as a good preventative.”*

Maintaining a good relationship with one's self and maintaining a close connection with the community, traditional culture, and one's place within creation was seen as protective. Losing that relationship and those connections were risk factors. This included maintaining lifelong commitments to the culture and with medicine societies. Participant 5 realized the importance of having a fulfilled life because *“emptiness and hopelessness”* is *“a risk for suicide.”*

Several participants noted that problems could arise from neglect of commitments. For example, membership in a medicine society is a lifelong commitment, but there are times when that commitment becomes neglected. Participant 1 revealed, *“...maybe that person belongs to one of the various societies and perhaps how they initially became a part of that then it's sort of like they're exhibiting those things again so they need to be able to renew those and take care of that again.”*

#### *Stopping Treatment*

Participants were asked how either the woman or the person helping would know when to stop treatment. In response, they largely left the determination when to stop treatment up to the person seeking help, increasing their sense of empowerment. Participant 3 summed this up: *“I would ask her. It's kind of up to them.”* Other participants indicated, *“She would know. When she feels capable herself (P4), and “When she was happy with herself, happy in her relationships, good self-esteem (P6). It was revealed that the woman would “be more happy, sense of her being content again, the negativity not expressed any longer...so she can certainly continue on, and that “she, herself will notice, she's feeling better, and even the person who's helping her will also know as well (P1). Additionally, the woman would be invited to “to come back if she*



*needs to (P4). In the event that “something that [she] didn’t see that starts to surface...and then [she is] ready to look at it so then [she’ll] come back at a later date (P3).*

When asked about stopping treatment, several participants focused on being able to read healthiness in a person’s body language. Participants indicated that regaining health can be determined because one can *“just read it in the body a lot of times” (P3)*, and noticing *“physical signs but ah but ah the expression on her face (P2)*. Participant 5 expanded on this by stating that healthiness is regained when healers, *“don’t hear the language of hopelessness, joy on her face. It’s a very physical expression that you look for. The spirituality of our joy is embodied in the language of the body (P5)*. Body language can also be seen in the way an individual carries himself or herself while engaging in activities.

- *She would be smiling a lot, not afraid to talk to people, not afraid to go out and enjoy herself, not afraid to laugh, she could find something good in all things, walk by herself (symbolically)...don’t need that support as much anymore...can do this to somebody else...can hold somebody else up (P2)*

Other indicators of return to health included noticing that she demonstrated that she learned new skills and perspectives.

- *... she’s gotten to the point where she’s OK with herself. Perhaps she learned some tools she knows how to keep herself encouraged and she’s learned about diet and nutrition that will help her with the focus and attention and the sadness...she’s learned about all of that. She feels confident in herself that she’s able to deal with whatever comes her way...we may pose the question, is there anything else? (P4)*

Also, treatment will likely be stopped once the person seeking assistance has regained a positive sense of him or herself, is reengaged in the community, and is able to be helpful to others.

- *...the minute she goes out and she can help somebody else you know to me that's the biggest thing is that when you have that strength to be able to help somebody else and that's the thing that you know that like you say we'd be working towards...you can look at things in a more positive direction and but you would never be alone never walk by yourself alone there would always be people with you so me to me it's just being able to stand behind somebody else now and hold them up...you don't need that support as much anymore now you can do this to somebody else you can hold somebody else up and to me that's you know what I guess how we would look at it (P2)*

### *Summary of Treatment Factors*

It should be noted that all of the respondents expressed a desire for more information than what was provided in the vignette in order to determine how to treat the symptoms. The interviewees expressed a desire to know the results of a holistic assessment in order to know how to proceed with treatment. Despite not having the results of an assessment, the participants provided responses to the interview questions. Table 5 lists the areas of treatment factors discussed (see Table 5).

Generally, work would begin with education about traditional Onlayote?a:ká values and strengths. Factors around treatment followed closely with those provided around the cause of the symptoms indicating that treatment would be tailored to the cause of the problem.

Treatment factors focused on empowering steps the woman in the vignette should do to help herself get better. The woman would be responsible for learning about her symptoms, maintaining connections in the community, and engaging in activities that she found personally fulfilling. A different step would be to connect with someone(s) who could help her. It was indicated that the helpers could be anyone with experience and knowledge about the types of symptoms the woman was experiencing. Anyone assisting the symptomatic woman would be expected to be supportive and to help her become

empowered. She would also be assisted to better understand her life and circumstances, which would include helping her to better explain her experience in a manner that includes relationships and spiritual considerations. Those helping the woman would work with her to educate her about cultural strengths, and ways to strengthen her spirit. They would also provide guidance about a traditional diet and any ceremonies indicated, including entering into ceremonial friendships to ensure that her relationships were mutually beneficial. The helper encouraging a healthy traditional diet was discussed, as were the strengths of traditional ways.

Participants expressed various courses for treatment. Some indicated that if a ceremony was implicated, then a positive outcome would be expected immediately following its completion. Others expressed that maintaining holistic health was a lifelong lifestyle and commitment. All of the respondents indicated that the outcome of treatment would be successful.

Maintaining relationships with others and the community and being committed to good overall health was seen as protective, while not maintaining those was seen as a risk factor. Ending treatment was largely left up to the person seeking assistance. It was noted that being healthy is very visible in body language and behaviors of engagement with others and community functions.

Table 5. Areas of Treatment Factors.

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Woman herself should do
Someone else should do
Treatment themes of:
Cultural education
Expected course
Outcome
When to stop treatment
Protective factors
Risk factors

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## *Integration of Findings*

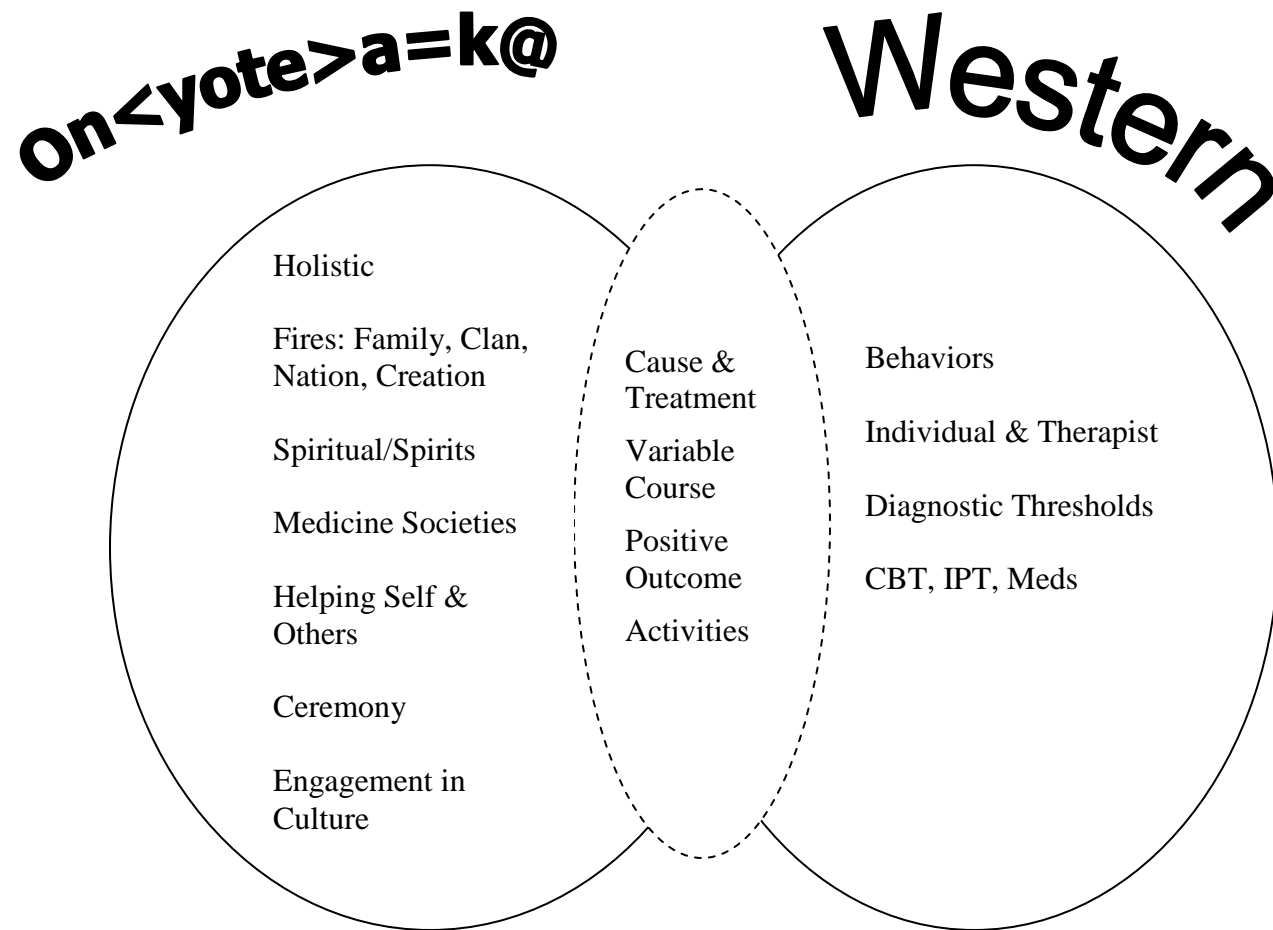
### *Similarities to Western View*

Analysis of the participant's interviews revealed that the traditional Onʼayoteʼa·ká view of mental health and illness overlap in a general or a global way with a Western view. The interviews revealed general constructs of (1) the existence of a problem, (2) that requires treatment, (3) which is expected to be beneficial. In addition, the interview results suggested constructs that (4) treatment will have a variable course and positive outcome, and that are (5) risk and protective factors related to the problem. These indicate that the Onʼayoteʼa·ká and Western systems converge in a global fashion.

### *Aspects Unique to Onʼayoteʼa·ká*

The analysis indicated that the Onʼayoteʼa·ká system, more than the Western system, emphasized relationships, interconnectedness, holism and balance, and the preeminence of spirit. Likewise, it seemed that treatment would be directly connected to the perceived cause, which is congruent with the Western system. However, the traditional Onʼayoteʼa·ká interviewees indicated that there could be numerous causes that fed into the symptoms; ultimately treatment would be geared toward determining how the causes had worked together to create unbalance and disconnection. Someone who treated the woman would be expected to take a number of things into consideration. These would include: *“the seen and unseen, spirituality, personal fire or spirit and what makes that up, sense of identity, variety of personalities played out in various relationships, intuition, female and male roles and responsibilities, ceremony, and diet and nutrition (P3, P4, and P5).* Figure 2 displays the points of convergence and divergence between the traditional Onʼayoteʼa·ká and Western psychology systems (see Figure 2).

Figure 2. The Areas of Overlap and Difference Between the Onłyote'a'ká and Western Psychology Systems.



However, analysis also revealed that the traditional OnΛyoteʔa·ká system is not as behaviorally focused on the presenting individual as the Western system. The OnΛyoteʔa·ká system considers an inter-working of multiple relationships on multiple levels, which allows for more points of access for diagnosis. There was less of a focus on the individual and more of a focus on how the person presenting interacted and related with others and the world. It was thematic that if a person were able to maintain good personal balance he or she would more be likely to maintain good relations. Also, the OnΛyoteʔa·ká practitioners indicated, to a person, that they needed more information than what was provided in the vignette in order to determine if there was a problem, what the cause was, and what treatment recommendations would be. The lacking information was about the woman's relationships and connections within the culture and community.

The traditional OnΛyoteʔa·ká system considered the domains of cognition, behaviors, affect, and somatic, however, they also included consideration that the domains were connected, or tied together, in some fashion. The participants' view that the domains of health were inseparable, and not considering the symptoms in the vignette to be mental, mood or an illness, caused the analysis of this section to go beyond the strictness of the questions being focused on the mental illness of major depressive disorder. The participants did appear to attempt to answer the questions as asked. However, it must be considered that overall health is the construct that the interviewees were operating within.

Treatment considerations did not focus on specific domains and were more holistic and included maintaining a connection and personal space with the larger community. This involved maintaining balance within and among domains and creation,

acknowledging and working with the unseen, engaging in ceremonies, and ensuring that the eight basic human needs (Antone, Miler, & Meyers, 1986) of being seen, being heard, to love and be loved, knowing safe loving touch, knowing that one is accepted and believed, knowing one's place and purpose in the world, knowing that one's existence is beneficial, and feeling secure, safe and at peace with ones' self and creation were being met and maintained. Although the cognitions were not singled out, a primacy was placed on the mind and thinking, and it was equated with the spirit in different ways. However, the spirit, and not the mind, was credited with tying all of the domains together.

Spirit was conveyed as a concept in two ways. In one way, it was used to describe a person's, or relationship's energy, while in another ways it was described as a different realm where entities or energies can interact and intervene with human problems. Thus the Onʌyoteʔa·ká conceptualization of mental health and illness is more holistic and energy-based than Western psychology. This is consistent with Onʌyoteʔa·ká and other Native views that everything is connected and therefore the traditional Onʌyoteʔa·ká conceptualization works with this idea.

The interview responses to questions about becoming unhealthy generally evoked responses involving issues of being out of balance and needing all areas of life to be healthy; that is each individual area needs to be healthy and in balance as well as maintaining balance and health among areas. Some general causes suggested included not maintaining relationships with healing spirits and medicine societies, those who have passed on, and with the community. This included becoming isolated and not engaging in community and ceremonial events. In this way they would have lost their place within the community. In addition, not eating a healthy diet consisting of foods identified as



nurturing the spirit and traditional foods was identified as a potential cause. Furthermore, there was some indication that the effects of contact with Europeans, and individualism could underlie health problems. This area seemed to indicate that a person could become separated or cut-off from their culture and no longer be in balance with themselves and creation at large. Naturally, death and grief were given as possible causes for the symptoms. Whatever the case, the cause of the symptoms would need to be identified and treated in order to stoke the ailing individual's fire, repair disruptions and traumas, and restore balance and cultural connections in order to get the person back to their usual self so that they would be able to help themselves and others.

Responses to questions about becoming healthy again followed from the reasons for becoming unhealthy. In essence a person would need to work toward determining what was involved with getting them unhealthy and then work to correct that. This work would necessitate the involvement of others, indicating that maintaining health is not solely the concern of individuals. For example, if a symptomatic individual was neglecting their diet then attention would need to be paid to that, or if ceremonies were not carried out properly for someone who died then he or she would need to work with someone to re-establish that ceremony. Regaining health ultimately involved restoring balance within and among all the facets of life.

### *Convergence and Divergence*

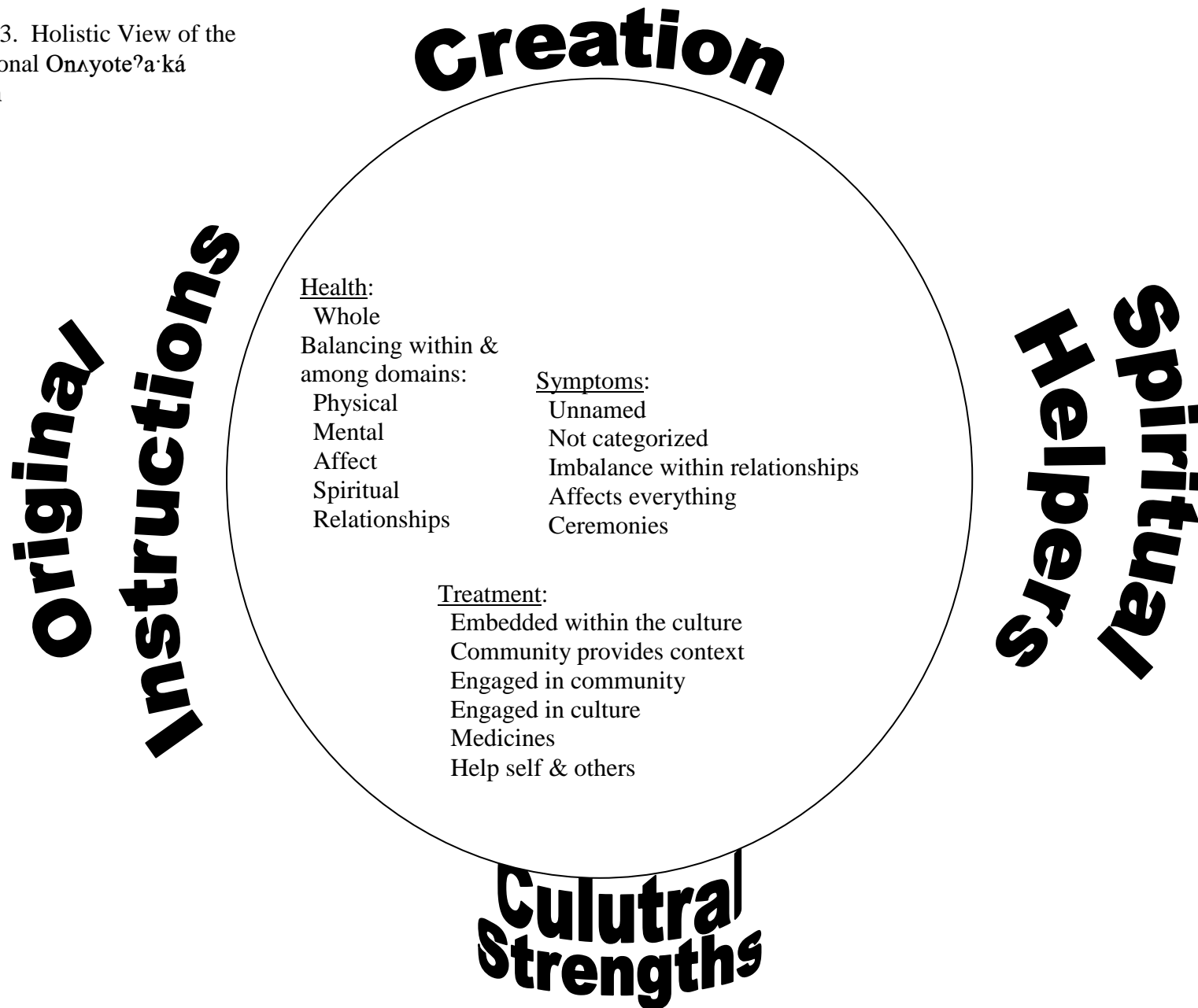
Figure 2 displays the points of convergence and divergence between the traditional Onlayote'a'ká and Western psychology systems. It can be seen that there is agreement that the symptoms are problematic and have a cause. There is also agreement that identifying the cause will inform and guide the treatment. Both systems indicate that

treatment will have a variable course and will likely result in a positive outcome, and they both attend to the types of activities an individual engages in.

The two systems have differing views on the points of diagnosis and treatment, however. The traditional Onlayote'a·ká system takes a holistic view and does not separate the domains of overall health. This leads to a conceptualization that all facets of life are intertwined and any or all of those facets may create symptoms and can be used for treatment. There is also an emphasis on the symptomatic individual's relationships, including the one with him or herself all the way to each and every relationship with all of creation. Spirituality, spirits, and ceremonies are also used in the Onlayote'a·ká system. The Western system uses diagnostic thresholds and empirically supported treatments, which limits the point of entry for diagnosis and treatment. That system also appears to be more focused on the relationship between one symptomatic individual and one therapist, which may also limit the relational functioning of the ailing person.

Figure 3 displays a model of the holistic view that the traditional Onlayote'a·ká system provides. The conceptualization of a symptomatic individual is encapsulated within the circle. All of those factors are attended to when determining the cause and treatment. The symptomatic individual and treatment system is surrounded by all of creation, the original instructions, cultural strengths and spiritual helpers. All of the people are able to connect with the spiritual realm to some degree. However, there are specially gifted people who are able to do this more readily and, if treatment involving general community and cultural strengths is not effective, are able to see into and gain assistance from spiritual realm to determine the cause and treatment of symptoms. See Figure 3.

Figure 3. Holistic View of the  
Traditional Onayote'a'ká  
System



## CHAPTER 5.

### Discussion

This study explored a traditional Onlayote'a·ká view of mental health, mental illness and practitioner's perspectives on symptoms consistent with a diagnosis of major depressive disorder by the EuroAmerican DSM-IV-TR. Extended Case Method was used. Data collection techniques included gathering open responses to a vignette and semi-structured individual interviews with questions about DSM constructs. The first aim of this study was to determine whether the traditional Onlayote'a·ká culture acknowledged a condition that the DSM-IV-TR would diagnose as the mental illness major depressive disorder. The second aim depended on the answer to the first aim. This aim considered that if the traditional Onlayote'a·ká culture acknowledged the disorder, then the potential causes, and proposed treatments including course and expected outcomes would be uncovered. The final aim of this study was to determine whether there was heuristic value in a diagnostic label such as major depressive disorder for traditional Onlayote'a·ká practitioners.

The answer to the first aim is not straightforward. When presented with a vignette of someone presenting with symptoms consistent with a Western, or DSM-IV-TR, diagnosis of major depressive disorder traditional Onlayote'a·ká healers acknowledged that the person presenting had a problem. However, the Onlayote'a·ká predate the DSM-IV-TR and modern Western psychological constructs and the participants expressed their understanding of the symptoms in ways that were not entirely consistent with DSM constructs. The traditional Onlayote'a·ká practitioners viewed the

symptoms in manner that did not separate mental health from overall health, and did not spontaneously separate health into domains such as cognition, affect, behavior, somatization, which is common in the Western system. Additionally, the participants did not consider the symptoms to be any type of illness or even a mood disorder. Therefore, the traditional Onlayote'a'ká participants did acknowledge that the symptoms were problematic. However, their understandings of the experience of the symptoms differed from a Western conceptualization.

The participants expressed some difficulty answering the interview questions, which were based on DSM constructs, due to a different conceptualization of the symptoms. Despite this difficulty they did offer their views on possible causes and treatment considerations of the symptoms. In this way, the interview responses provided insight into aim two. The participants indicated that the vignette did not provide enough information to accurately determine a cause of the symptoms. They expressed a desire for more information about family and community relationships, and cultural beliefs. A potential cause of the symptoms included being disconnected from relationships including those with one's self, other people, cultural beliefs, and spirituality. Treatment considerations would be specific to the cause and included seeking assistance from someone experienced with working with those symptoms and that assistance would provide a positive outcome. In addition, it was noted that spirituality ties all facets of life together and efforts need to be made to strengthen a person's mind and spirit. A spiritual realm also exists wherein spiritual entities can assist with determining causes and treatments of symptoms and can intervene directly if needed.

The third aim of this study was to determine whether Western-based diagnostic label of *depression* held heuristic value for traditional Onʼayoteʼaʼká. The answer to this aim was no. The study participants did not use a common diagnostic label and, in fact, declined to provide any name for the symptoms at all. When pressed on interview, they did offer some labels for what the symptoms might be capturing. However, they did not do this spontaneously and there was little agreement among the participant about the meaning of the labels. The traditional Onʼayoteʼaʼká system viewed health in a holistic manner, which allows for numerous points of access for identification of possible causes and treatments. This precluded the utility for any one diagnostic label.

In summary, the traditional Onʼayoteʼaʼká practitioners did acknowledge that the symptoms presented in the vignette were problematic. However, they did not view them in the same manner as Western-based psychology and diagnosis. Therefore, points of convergence and divergence between the two systems in the areas of conceptualization of the problem, treatment of the problem, and the problem's impact were explored.

### *Conceptualization*

As stated earlier, the Onʼayoteʼaʼká practitioners declined to provide a shared diagnostic label for the symptoms. This was congruent with their expressions of having a great deal of difficulty conceptualizing health in a categorical or domain specific manner. They viewed health holistically and explained that all areas of health were tied together in some manner. The construct of spirit was introduced as a means to explain this binding force. Spirit will be further explained below. The study participants indicated that in order to understand the symptoms within the context of the woman in the vignette a holistic assessment would need to be completed. The information gathered from the

assessment would inform about her physical health, spiritual beliefs and practices, connection with the traditional Onʼayoteʼa·ká culture, and her relationships.

These relationships included those with herself, family, clan, and spiritual entities and medicine societies. The assessment would also uncover information about whether ceremonies that needed to be done were conducted or if something was necessary to complete, as can be the case with deaths or certain dreams. Furthermore, information would be gathered about her desires for services and how best to help her become empowered to maintain her own health.

### *Distinguishing Mental Health and Health*

There was discussion with all of the respondents about having difficulty answering the interview questions because the questions seemed to want the responses to separate mental health from overall health. The participants indicated that all of the personal and inter-relational domains are intertwined and inseparable. All of the areas of life need to be healthy in order for any of the other areas to be healthy. Further, the four domains of cognitive, affective, behavioral and somatic, which were the ones interviewed around, were all of the human realm and concrete.

The participants expressed confusion when asked questions commonly used for DSM diagnosis. In addition to the questions being problematic because they required answering in term of separating mental from health, these included questions about deficits and dysfunction. Much like categorization, these are constructs that are not readily within the conceptualization of health for the traditional Onʼayoteʼa·ká. It was expected that each person would function to the best of their ability and work to fulfill their purpose in life using their individual gifts.

Being unhealthy was described as being out of balance within and among the various facets of life. It would appear that being unhealthy must involve a problem with spirit, since spirit binds life's areas together. Some of the study participants, including the Onlayote'a·ká language expert, indicated that the mind, or thinking, was a primary construct among the Onlayote'a·ká. In addition, the participants who used the Onlayote'a·ká language identified the mind and the spirit as slightly different aspects of the same concept. Any disruption in the force that unites existence, or spirit, will affect all other areas of life including the mind and relationships with community and other forces of creation. Being healthy was described as maintaining spirit by keeping its fire burning brightly. This can be accomplished by being a part of the very fabric that binds everything together by caring for one's self and engaging in mutually beneficial relationships. It was noted that spiritual forces made themselves available at the time of creation to be beneficial to humankind as long as the people worked to maintain those relationships. The responsibility for being healthy lies within the individual who is part of the culture around them.

### *Spiritual*

The study participants indicated that the binding force that ties areas of health together is spirit. They discussed spirit in terms of its strength both as a personal resource and power within relationships. Relationships discussed included those with one's self, other people and other forces of creation. The metaphor of a fire was used to indicate that this strength can burn brightly when properly maintained or it can be weak and nearly at the point where it will be extinguished if it is neglected. In order to



maintain this fire, an individual needs to take charge of their own health and well-being and engage in mutually beneficial relationships.

The symptoms were discussed as a disruption of a person's fire or spirit and that their fire was not burning as nicely and strongly as it was intended. There was some discussion of the need to build their fire, or spiritual power, back up using encouragement and empowerment so that they could get back to their usual self and be of help to others. Relational fires needed to be built up and maintained as well. Being symptomatic could be the result or product of letting one's fire or spirit get low.

The study participants further noted that the spiritual domain was crucial and of a different realm than the four domains of cognitive, affective, behavioral and somatization, which were identified as concrete. Spirit was described as being expressed in all facets of life and providing the ability to remain and be aware of interconnection with all of creation. It was noted that it was important to work with the concrete domains. However, there was more focus on the strength of fires. Both relational and individual fires are tended by engaging in nurturing relationships, and carrying out one's roles and responsibilities. In addition, it was described that an individual should work to ensure that their fire is made up of kindness, compassion, consideration, empowerment, and acknowledgement. These "logs" are found in mutually beneficial relationships.

The concept of spiritual helpers, or entities, was introduced briefly and it was noted that spirits would assist with ceremonies that could need to be completed to alleviate the symptoms or that spirits would assist in the form of medicine societies. It was noted that unless one was a member of one of the medicine societies that they would not have intimate knowledge about it and the medicine society's workings. In addition, if

one were a member, they would not discuss details about the society outside of being engaged in a healing ceremony. Therefore, this is all of the information that was provided about medicine societies at this time.

### *Treatment of the Problem*

Treatment was discussed in a holistic manner and included tending to the domains of cognition, affect, behaviors, the body, and the spirit and spirituality. Attention also needed to be paid to relationships within creation. It was acknowledged that everything in creation came from one source and was provided with a spirit when it was created. Holistic was described as acknowledging that the domains were not separate and ensuring that all areas of life were healthy because if any area was not then it was not possible to have complete health. Furthermore, all areas of life were described as being intertwined, and there was an emphasis on the inter-relatedness of the mind and the spirit. This connection was further expressed in terms of the mind being seen as bringing awareness to spiritual matters and the connections with the rest of creation. The spirit was discussed in two ways. It was discussed as a person's energy or fire, and it was also discussed in relation to a spiritual realm where individuals or groups of people can interact with spirits who are able to assist with symptoms and disruptions in people's lives. Further, they indicated that balance was sought within and among all of the areas of life, and that spirit was what tied those together and also was what provided the balance. Often times a person neglects their spiritual being and becomes unbalanced. He or she may attempt to compensate with the mind, but this only serves to further the imbalance because what is needed is more attention to spirit and the interconnectedness of creation. In this way

humans must remember that they are only one important part of creation and not placed above or below the rest.

Conceptualization of treatment depended on what the perceived cause of the vignette symptoms were, suggesting that treatment procedures would be adapted to address the cause of the problem. The study participants indicated that they would need more information, including the results of a holistic assessment, prior to being able to determine how to address treatment. The participants did offer some basic treatment strategies, despite not having as much information as they desired.

Treatment was discussed in two ways. One way was about what the woman in the vignette could do, and another way was about what someone else could do to address the symptoms. One of the steps suggested for the woman to make was to connect with someone in the community who was experienced with having personally been through and/or worked with the symptoms. The woman would also be encouraged to educate herself about the problems she was having so that she will be empowered to care for herself. In this way she would be better prepared to enter into and maintain healthy relationships. In addition, it was indicated that she should ensure that she ate a wholesome diet that included traditional foods in order to care for her physical health. It was acknowledged that foods provided the building blocks for the mind to operate properly. Each of the traditional Onʼayoteʼa·ká practitioners indicated that they had seen people with similar symptoms and would be willing to work with the woman in the vignette.

Someone else working with the woman in the vignette would remind her about values and strengths within the traditional Onʼayoteʼa·ká culture. Retelling and exploring

the foundational stories of the culture including the creation story, the Great Law, and the personal thanksgiving would convey reminders about the values. The creation story helps with understanding our place within the universe, and the positives and negatives in life. The Great Law includes teachings on compassion, and the personal thanksgiving reminds about gratitude. Furthermore, the Great Law provides instruction about how to live with *Kaʔnikuhli·yó*, or a good mind. The mind was recognized as being aware of how to live within creation in a way that considered compassion and innocence, caring and connectedness, encouragement, empowerment, spirituality, peace and justice, humility in service for the people and the Creator. A good storyteller would set the context for these stories by creating a setting where traditional cultural feelings of love, peacefulness, and compassion would be evident. A discussion could then be had about living life according to peace and harmony as originally instructed at the time of creation.

Participants expressed various courses for treatment. Some mentioned that certain ceremonies might be helpful. However, discussions about specific ceremonies were similar with those about medicine societies and no specifics were offered. Those who did mention ceremony indicated that if one was implicated then a positive outcome would be expected immediately following its completion. Others expressed that maintaining holistic health was a lifelong lifestyle that one would never be done working on. All of the respondents indicated that the outcome of treatment would be successful. Maintaining relationships with others and the community and being committed to good overall health was seen as protective, while not maintaining those was seen as risk factors. Ending treatment was largely left up to the person seeking assistance. It was noted that being healthy is very visible in body language and behaviors of engagement

with others and community functions. Likewise, it would be evident when someone was not longer suffering from symptoms because they would be engaged in community activities and available to help others.

### *Impact on Relationships*

Symptoms and disruptions similar to the one in the vignette would need to be worked with on individual and relational levels. The basis for discussing the symptoms appeared to be the inter-workings of personal and relational fires, rather than focusing on an individual's thoughts, feelings, somatic complaints or behaviors. The traditional Onayote'a·ká practitioners viewed any problem as being intertwined with various domains of functioning and the individual's impact on social circles including relationships with everything in creation. This inseparableness is impacted by disruptions anywhere in the system.

The ultimate goal of treatment was to bring balance and peacefulness among the relationships that a person encounters. Attention was paid to assisting the person to improve their relationship with their self, which in turn would provide a healthy foundation to engage other relationships. A good relationship with the culture would begin with maintaining a connection with culture bearers and titleholders such as the Clanmothers, Chiefs, and Faithkeepers. These people are tasked with ensuring that the people understand their roles and responsibilities, maintain ceremonies, and resolve conflicts. These are the people who ultimately hold the traditional responsibility for prevention and intervention of disruptions, conflicts and symptoms.

Individuals, such as the woman in the vignette, often become more withdrawn from community support and find themselves isolated. This is problematic to both the

individual and the community. The individual becomes cut off from the very support that could assist them, while the community misses out on the strengths and gifts that person brings to assist others and with fulfilling her roles within family, community and creation at large. A ripple effect takes place. For example, the woman in the vignette is likely neglecting even her own immediate family leaving her husband and children without someone fulfilling a wife's and a mother's roles and responsibilities. This leaves holes in her family member's lives, which leaves them less whole and less able to fulfill their roles and responsibilities within the larger community.

These impacts are much greater in contemporary times because of the effects of contact and colonization, which has resulted in less people adhering to traditional cultural ways. This change has seen many people to be more individualistic, which places them in a much more isolated way than people who adhere to traditions and maintain a closer connection to the community. Historical times were described in a manner when all the people worked together with caring and compassion. It is unclear how often people suffered from symptoms such as those in the vignette in historical times. However, it is clear that there were ways to assist with symptoms, and any negativity created by disruptions would have been able to be kept to a minimum. Since the people were like-minded in historical times, the examples and role models would have been healthy self-sufficient people striving to work together. The negative effects of someone who was not well would not have had the opportunity to spread. However, in contemporary times there are fewer people who strive to adhere to core cultural teachings and so negativity has greater opportunities to increase its influence.

### *Onlayote'a·ká and Western Comparison*

In an effort to translate a bridge between the traditional Onlayote'a·ká and Western-based psychology systems comparisons will be made concerning the interview questions asked in this study. The symptom and health constructs of etiology, nosology, and diagnostic labeling will be compared. Points of comparison will be reviewed for areas of symptom impacts. Finally, treatment factors will be compared.

#### *Symptom and Health Constructs*

*Etiology.* Causes of depressive symptoms are poorly understood in the Western psychology system (First, Frances, & Pincus, 1997). However, effective treatments focus on dysfunctional thinking and maladaptive behaviors with cognitive-behavior therapy (CBT), interpersonal relations including interpersonal deficits, role transitions, disputes and loss with interpersonal therapy (IPT), and biochemical imbalances with psychopharmacological therapy. Pharmacological treatment focuses solely on the individual, and CBT focuses on the individual to a large degree and their engagement in activities. IPT focuses on relationships and fitting in with social situations.

The Onlayote'a·ká system did identify some roles the symptomatic individual plays in acquiring their symptoms. However, much of the personal responsibility involved maintaining connections with other people, the community, and creation at large. The individual was also responsible for maintaining their own physical health and engaging in activities that strengthened their mind. There was acknowledgment that a proper diet provided the building blocks for the brain to operate correctly, which may in some way resemble psychopharmacology. Traditionally the Clanmothers held the responsibility for assisting the people with role transitions, and the Chiefs held the

responsibility for assisting with resolving conflicts. A close-knit community where dozens of families lived in the same Longhouse would have provided plenty of opportunities for honing interpersonal skills and deficits would have been unknown. Furthermore, engagement in traditional community social activities and ceremonies was the expectation and therefore the people would have been involved in pleasurable activities on an ongoing basis. It seems that the traditional OnΛyoteʔa·ká lifestyle may have been preventative for developing depressive symptoms. However, it was noted that in modern times many of the people do not follow the traditional ways and have become more individualistic, which has resulted in many people being isolated from the strengths of the culture.

Certainly the effects of personal loss and grief can manifest as symptoms similar to the ones presented in the vignette. Alcohol, drug, and interpersonal abuses can manifest in that way too. Clearly these effects are seen in both the Western and OnΛyoteʔa·ká systems.

*Nosology.* Viewing psychological disorders as discrete categories or along a continuum of functioning are methods of classification (Klein, Shankman, & McFarland, 2006). Classification provides a system for mutual understanding for those who share that same view by supplying a shorthand description of the disorder (First, 1992). This understanding is meant to aid clinicians, researchers, and instructors to identify and manage those disorders. Furthermore, individuals who are distressed by psychological disorders symptoms may find comfort in knowing that their experience is not unique, but rather has a history of being identified and studied (First, Frances, & Pincus, 1997).



Historically, psychiatric classification has taken two different approaches to classifying disorders, with the first being etiological and the second being descriptive (First, 1994). Etiological approaches create categories based on disorders having the same underlying cause. However, this approach is limited because the underlying causes of psychological disorders are poorly understood (First, Frances, & Pincus, 1997). A descriptive approach relies on clinical descriptions of symptoms that are thought to be indicative of the disorder and may provide insight into a common etiological process for different categories of disorders (First, 1994). The DSM-IV-TR (APA, 2000) provides a diagnostic system that places psychological disorders in a discrete categorical manner based on descriptions of symptoms.

The results of this study suggest that the traditional Onlayote'a·ká view health holistically and do not use a categorical approach to diagnosis. The symptoms in the vignette were not viewed as an illness and were not viewed within the mental domain. There was a desire not to separate mental health from overall health and there was no mention of a subcategory called mood. The participants did acknowledge the four domains of cognitive, affective, behavioral, and somatization as each being important to health. However, they viewed these domains, along with all facets of life as being interconnected and inseparable.

Interestingly, the Onlayote'a·ká language does not have a set of vocabulary for affect and therefore that concept is not indigenous to the culture. Perhaps there was not a need to spend time discussing affect when the people lived in a manner where everything they needed was provided right along the path of life. At that time it is likely that sadness did not exist outside of grief. However, in modern times the symptoms in the vignette

seem to be fairly common and some of the Onʼayoteʼa·ká participants have begun to work more with affect as it pervades the contemporary experience. Even though the traditional Onʼayoteʼa·ká acknowledged the symptoms in the vignette as a condition warranting assistance, their understanding of the experience of the symptoms is in a much different manner than the Western system.

*Labeling.* The vignette, which was adapted from a DSM-based casebook, was designed to be identified as major depressive disorder by a Western psychological clinician. That diagnostic label provides heuristic value to other clinicians who may be informed about the woman seeking help in order to provide an effective empirically supported treatment. In this way a common label, coupled with the presenting individual's specifics guides the most efficacious treatment.

The traditional Onʼayoteʼa·ká did not use a common diagnostic label when discussing the symptomatic woman in the vignette. The participants indicated that there was not enough information provided in the vignette to determine the cause and likely treatment of the symptoms. Furthermore, it was expressed that a name would not be given for the problem that the woman was experiencing, and the participants indicated they would use the woman's words rather than provide them for her. When pressed some Onʼayoteʼa·ká words were offered to describe the experience of the symptoms. However, there was little agreement on the meaning and translation of the words provided. It appears that a common diagnostic term is not useful for the traditional Onʼayoteʼa·ká for at least two reasons. First, the meanings of words used depend on the context and situation. The Onʼayoteʼa·ká language is very descriptive and precise. Comparable with other oral languages, words used are meant to be very specific to the situation.

Therefore, there really is no such thing as a common label. The second reason is that there are numerous points of entry for diagnosis and treatment of symptoms in the OnΛyoteʔa·ká system, which will likely leave any one diagnostic label lacking.

### *Symptom Impacts*

*Costs vs. effects.* The Western system has clearly associated costs, and categories of costs, with major depressive disorder. These costs range into the billions of dollars annually. None of the traditional OnΛyoteʔa·ká participants mentioned monetary costs associated with the symptoms in the vignette. They discussed the impacts of being healthy or unhealthy in the ways that affects the intertwined relationships the healthy or unhealthy individual is involved with. Any disruption, at any point in the system of creation, can negatively affect any other point at any time. In this way, a symptomatic individual is not only suffering him or herself, but is also creating imbalance within his or her relationships. Likewise, a healthy individual has the opposite, and positive, effect on his or her relationships. Perhaps costs associated with the traditional OnΛyoteʔa·ká system would have to be measured in quality of life and relationships.

### *Treatment Factors*

*Roles.* The traditional OnΛyoteʔa·ká and Western-based systems seemed to largely converge regarding the roles that the symptomatic individual and others would play in treatment. In both systems, the individual is responsible for seeking out assistance from someone with experience with whatever problem they are experiencing. Also, similar with psychotherapy, the individual would be expected to play an active role. Both systems focused on the mind and thinking, positive relationships, and engaging in supportive activities. Additionally, both systems would expect a variable course

depending on the particulars of the case and what the symptomatic individual was willing to put into his or her own treatment. Professionals in either system would expect positive outcomes if the proposed treatment was adhered to.

*Termination.* There may be some points of divergence between the two systems regarding when to stop treatment. None of the traditional Onlayote'a'ká practitioners indicated using a manual for treatment or a preset number of sessions, as is sometimes the case in the Western system. Additionally, the Onlayote'a'ká indicated they would look for physical signs and the symptomatic individual's body language to tell when they were no longer needing assistance. This can be contrasted with no longer meeting DSM diagnostic criteria as would be used in the Western system.

*Protective factors.* The Onlayote'a'ká system provides some protective factors in addition to maintaining functional thinking and engaging in adaptive behaviors. Adherence to traditional cultural strengths including revisiting the lessons in foundational stories, and engaging in community social and ceremonial activities was strongly recommended. A wholesome diet that included traditional foods was prescribed. This diet was also to include foods such as berries that are known to strengthen the spirit. Spending time and effort building a good relationship with one's self is primary to preventing symptoms. It is very important to have a belief in the systems of the culture and that there are forces operating outside of day-to-day awareness that are available for assistance. Having a belief and faith in these spiritual entities and powers, along with maintaining a spiritual relationship with all of creation, is fundamental to having a balanced and healthy life.

### *Clinical Implications*

The Onlayote'a'ká and Western-based psychology systems have points of convergence and divergence when considering symptoms consistent with DSM diagnosed major depressive disorder. These points can be helpful when providing assistance or services for a traditional Onlayote'a'ká person. Someone involved with healing symptoms in a traditional Onlayote'a'ká setting does not find value in labeling or diagnosing the symptomatic experience. However, the foundation of treatment begins with fundamental cultural teachings. These teachings are found in the creation story, the thanksgiving address, the Great Law and the teachings of Skanatali'yó. These stories teach about our place within creation as human beings, and the original instructions of how to live in peace and harmony with creation. They also teach about the up and down flow of life and provide lessons about gratitude and compassion. A traditional Onlayote'a'ká person should have some knowledge and understanding of these stories and lessons. However, in times of imbalance reminders of these cultural strengths would be highly recommended.

Another fundamental treatment consideration is ensuring that a good wholesome diet is maintained. This diet should include traditional foods. These types of spirit strengthening foods are provided at community functions and ceremonies. Therefore, the person seeking assistance can attend social or ceremonial events and acquire this much-needed sustenance. At the same time they will be able to strengthen their community ties and relationships with family and friends. In the case or ceremonies, all of creation is invited to attend and the person can then also strengthen their ties with creation at large. Naturally, people should not abuse substances. In fact, a traditional Onlayote'a'ká

person should not use substances at all as the instructions indicate that no mind altering substances should be allowed to enter the body. Maintaining clear-mindedness is very important.

An Onlayote'a'ká person should be encouraged to spend time reflecting on the lessons the culture has to offer. This reflection time should include attention being paid to developing that relationship with one's self. This fundamental relationship is fostered by learning to listen to and trust one's self, and by building an understanding of one's place within the community and creation. A person may need assistance with this, especially if they were not raised within the culture. If that is the case, they should seek someone out who is familiar with this process with whom they can meet regularly. These meetings will likely also include discussion of the person's dreams and intuition. This will be done in order to foster their ability to connect with the spiritual realm. An understanding and trust of the spiritual realm needs to be developed in order to comprehend and appreciate one's place within creation. Someone treating an Onlayote'a'ká person must be prepared to work with these other realm experiences. In historical times, and within the Onlayote'a'ká language, there was no concept of psychotic. As someone develops his or her see, their experiences may resemble a break from reality, both to themselves and an inexperienced clinician. There are times when these experiences indicate the need for a ceremony or involvement of a medicine society. These are times when a referral should be made to the community's titleholders and/or seers.

These foundational relationships pave the way for entering into other healthy and mutually beneficial relationships. In modern times, many people have experienced

childhood trauma and this will need to be worked with in order for the person to trust and forgive themselves and others. Anything other than looking for the good is not culturally appropriate. Hanging onto old hurts is not looking for the good. It is likely that an Onʼayoteʼaʼká person seeking assistance would want others included in the treatment. This should be encouraged because healthy relationships with everything in creation are necessary to maintain a balanced and symptom-free life.

### *Theoretical Implications*

These current findings are compared with the foundational conceptual and emerging works from the area of Native American Indian mental health, and the Western-based psychology's biopsychosocial model. The three pertinent pieces of Native American Indian mental health theory include Eduardo Duran's work with soul wound and worldview differences (1990, 1995, 2006), Duran, Duran, Yellow Horse Brave Heart, and Yellow Horse-Davis's (1998) work along on the intergenerational transmission of the negative effects of contact and colonization, and Walters and Simoni's (2002) Indigenist Model.

Duran (1990) presents differences he has noticed between Western and general Native American Worldviews as a backdrop to his concept of soul wound. The two main differences he delineates are temporal approaches and non-compartmentalization. Duran offers that Native American Indian people approach the world in a spatial fashion rather than a temporal one. This indicates that there is a focus on the location of where events took place as opposed to when they occurred. He further proposes that Native American people do not necessarily conceptualize in terms of a linear function where there is a beginning and an end, and instead think in terms of time being circular. Duran suggests

that Native American Indians generally emphasize the space element, rather than the time element, of the space-time continuum. This indicates that Native American Indian people view the world in a manner that “may not have the same linear quality that it does for a Western person” (p. 19).

Duran (1990) also discusses differences he has noticed regarding the Western tendency to separate experience, whereas Native American Indians generally do not compartmentalize experiences and instead endeavor to understand the totality of systems. He points out that unlike Western ideology, which holds the “idea of the world or creation existing for the purpose of human domination and exploitation” the Native American Indian worldview in general “is one in which the individual is part of all creation living a life as one system and not in separate units that are objectively relating with each other” (p. 20). Duran’s pan-Native concepts indicate that when a Native client experiences symptoms, he or she “has lost the ability to be in harmony with the life process” (p. 20), and move in “harmony with the season, the wind, and all of creation” (p. 21).

The finding of this study largely agree with Duran’s pan-Native concepts of holism, balance and non-compartmentalization being identified as being core across Native American Indian worldviews. Embedded within this worldview is a value on maintaining harmony in relationships with one's self, family, community, Nation and the rest of creation (Duran, 1990). Garret and Walkingstick Garret (1994) added to this when they noted that Native American Indians in general rely on their specific core cultural values, which include relationships and a connection to their history for a sense of belonging. The traditional Onʼayoteʼa·ká agree that seemingly far-reaching relationships



are important and actually central. The above indicates that conceptualizations that are not categorical, and do not view domains as separate is inline with findings from this study. Furthermore, Duran (1990) indicated that Native American Indian people generally do not view themselves as separate from other systems within creation and therefore there is no loss of connectedness with non-human systems. Again, the findings of this study with traditional Onlayote'a·ká place greater emphasis on the intertwined nature of all things over individuals agree with that idea. Diagnosis is approached in a different manner among Native American Indians and traditional Onlayote'a·ká. Attempts are made to understand symptoms within the context of inter-relatedness and (dis)order is then determined once that inter-working is understood.

Concepts about a temporal or spatial approach to the world were not expanded on by the participants of this study. However, the responses emphasizing an interconnectedness of all things may have precluded a discussion about time. There was a feel during the interviews that time was de-emphasized. This was made evident when discussing the length of treatment. No set limits on the number of sessions would have been made. Also, there was indication that as much time as needed would be spent for each meeting with an ailing person. This has been the experience of this investigator when engaged in a relationship with traditional Onlayote'a·ká mentors. It is unclear at this time if the traditional Onlayote'a·ká's concepts of a temporal or spatial approach to the world agree with Duran's concepts, although it seems likely.

This study did not focus on what the effects of contact and colonization have been for the traditional Onlayote'a·ká and whether these effects have been passed on from generation to generation as has been indicated by Duran, Duran, Yellow Horse Brave

Heart, and Yellow Horse-Davis (1998), and Yellow Horse Brave Heart (1998a, 1998b, 1998c, 1999). However, the participants in this study did reveal their belief that contact with Europeans, Christianity and Western education have been very negative for the Onʼyoteʼaʼká people. Furthermore, some participants indicated that these negative effects, when not dealt with and healed, can get passed on from generation to generation until the negative behaviors and thought patterns become usual and accepted.

This study uncovered points of difference between historical and contemporary times. These differences indicate that times prior to contact were happier with everyone working together with a common understanding of community, the culture, and their place within creation. This compares with modern times when less people follow the traditional ways and more people are concerned with their individual interests. Being focused on one's self creates a chasm between one's self and relationships with other people, ceremonies, and creation. This leaves one isolated from the strengths of the community and the culture. This study revealed that there is likely an intergenerational transmission of the negativity associated with contact and colonization. The largest negative effect is the cutting off of the people from their own culture's healing ways. This not only robs the individual of healing, but also robs the community of that individual's gifts. However, this study also provided traditional Onʼyoteʼaʼká means of healing the negative effects of contact and colonization, which is something that has received little attention in the past.

Walters and Simoni (2002) created an Indigenist Model of trauma, coping, and health outcomes. Their model demonstrated that cultural buffers could mediate the negative effects of stress due to trauma. The participants in the current study did not

necessarily attribute the symptoms to the effects of trauma. However, trauma due to the effects of contact and those due to interpersonal abuses were indicated by some participants. The Indigenist Model lists identity attitudes, enculturation, spiritual coping, and traditional health practices as cultural buffers. This current study did not explore the effects on health of identity, acculturation, or enculturation. However, this current study did reveal that spirituality and engagement with helping spiritual entities was primary to health. Additionally, engagement in traditional health practices including attending community events, ceremonies, and maintaining a wholesome traditional diet was indicated for health by this present study's participants. The findings of this current study agree in part with the ability of cultural strengths to buffer the negative effects of symptoms. However, not all of the same dimensions were explored as were with the Indigenist Model and therefore the model could not be confirmed in whole.

The traditional Onʼyoteʼaʼká practitioners recognized that everything in creation is connected and inseparable leaving a holistic conceptualization of health rather than a categorical approach. Native theory is in agreement with the field of physics, which recognizes that there is interconnectedness among all things. The hard sciences discuss this in terms of energy and explain that there cannot be a transfer of energy without an impact on the rest of the system. Native theory and the findings of this study can perhaps be viewed in a fashion that is similar to cellular biology. The intercellular fluid is the substance that binds the components together and it's also the substance that disease and healing travels through. Native theory is similar with the view that spirituality is the substance that binds and provides an avenue for positive and negative influences to impact relationships and also an avenue for assisting with the healing.

Pan-Native American Indian conceptual and theoretical works need to be expanded to incorporate more health constructs from individual First Nations. If these works do not expand and explore the nuances and applicability to specific First Nations they run the risk of perpetuating a homogenized view of Native American Indian people. There are hundreds of First Nations, speaking hundreds of languages, and following hundreds of their own traditional teachings. This risk can reach great magnitude if all of these individual First Nations' cultural strengths are lost or traded for a one-size fits all pan-Native approach. As found with this current study, the way for traditional Onlayote'a·ká people to heal is through traditional Onlayote'a·ká beliefs and methods. The Onlayote'a·ká people were placed on this earth with specific instruction about how to be Onlayote'a·ká people. The symptoms experienced in modern times are due to being cut off from those original instructions and only through understandings specific to the Onlayote'a·ká will healing occur for Onlayote'a·ká people. This current study extends considerations for existing theory by moving from the negative effects of colonization and views of mental illness toward a model of health based in traditional cultural strengths.

The results of this study with traditional Onlayote'a·ká practitioners adds to existing Native American Indian theory about mental health. This focus on one First Nation revealed nuances specific to that culture. For example, this study illustrated that cultural values and strengths are found in core stories such as the creation story, the Great Law and the personal thanksgiving. These stories provide a foundation or compassion, acceptance of life's positives and negatives and gratitude that go beyond holism and balance. In addition, it was found that the individual plays a vital role in maintaining

health and well-being and is responsible for maintaining their social roles and responsibilities. They are also responsible for engaging in mutually beneficial relationships. This extends existing pan-Native theory that has focused on the interconnectedness that the individual is part of, but thus far has neglected the role of the individual within those connections.

The biopsychosocial (BPS) model, first proposed by George Engel (1977), theorizes that interactions in the biological, psychological, and sociological domains all play a significant role in an individual's functioning. Likewise, mental illness can be exacerbated by any or all of these domains. Engle proposed that the domains are interlinked and inseparable in the way they influence each other. In this way, whatever affects one domain will necessarily affect the other domains and vice versa (Smith, 2002). This means that the totality of human experience is really a combination of biological, psychological, and sociological factors. The influence of this theory can be seen in the diagnostic criteria for major depressive disorder in the DSM. Depression is listed as a mood disorder. However, diagnostic criteria include consideration of physical, behavioral, and somatic symptoms. Furthermore, in order to meet criteria for diagnosis the symptomatic individual must be experiencing clinically significant distress in at least one domain of social functioning.

The BPS theoretical model appears to be largely in agreement with the traditional Onayote'a'ká conceptualization of health and the human experience. However, the model does not theorize about whether there is some force that binds the biological, psychological, and sociological domains together. The traditional Onayote'a'ká system indicates that the construct of spirit binds, and flows through, the domains of life.

Furthermore, the BPS theory is widely accepted among mental health professionals (Smith, 2002). However, it is not clear how the model is being systematically incorporated into Western-based empirically supported treatments for depression. This is contrasted with findings from this study, where the traditional On̓ayoteʔa·ká view the understanding of the intertwined relationships among all things, including domains of functioning, as critical to begin to comprehend the origin and resolution of symptoms.

This study's findings also provided further delineation of the role of spirituality. Previous literature has commented on the need for a belief in non-human forces within creation and the On̓ayoteʔa·ká system provided a more detailed description of what that is. While delineating what spirit was not a focus of this study, the results indicated that spirit includes keeping one's self and relationships healthy and bright. This provides a necessary comfort and fortitude that allows one to be aware of their connectedness with all things. In addition, spirit was identified as the construct that binds all the domains of life and forces of creation together. It is like a fabric or energy that is impacted by everything that it is connected to, which again is everything. Spirit acts as a conduit to transmit negative and positive energy, illness and health, amongst creation. Non-human spiritual forces were differentiated from the general spirit and were credited with being available to assist the people when they suffer. Any type of healing is also a spiritual healing. Again, this adds another dimension to the construct of spirit that has not yet been discussed in the literature. It will remain to be seen how other specific First Nations conceptualize mental health to determine how the traditional On̓ayoteʔa·ká conceptualizations match and how the general theories evolve.

### *Strengths and Limitations*

There will likely always be a debate about the strengths and weaknesses of qualitative and quantitative methods. The research topic and aims determine which method is the appropriate one. This study utilized extended case method (ECM). It is a qualitative method that extends existing theory while allowing for new themes and theory to emerge from the data. This was the best method for this cross-cultural study. There were no preconceived outcomes for the results; only a framework based on existing studies and theory. The aims were to allow the data to determine the points of convergence and divergence between traditional Onayote'a'ká practitioners recognized that everything in creation is connected and inseparable leaving a holistic conceptualization of health rather than a categorical approach.

Native theory is in agreement with the field of physics, which recognizes that there is interconnectedness among all things. The hard sciences discuss this in terms of energy and explain that there cannot be a transfer of energy without an impact on the rest of the system. Native theory and the findings of this study can perhaps be viewed in a fashion that is similar to cellular biology. The intercellular fluid is the substance that binds the components together and it's also the substance that disease and healing travels through. Native theory is similar with the view that spirituality is the substance that binds and provides an avenue for positive and negative influences to impact relationships and also an avenue for assisting with the healing practitioners' and Western-based psychology diagnostic constructs.

ECM allowed all of the data to be attended to, which is congruent with Native methods of gathering knowledge. The method and study's rigor was ensured by

maintaining multiple levels of data analysis with interpretation by the primary researcher as an insider-expert. The relatively small number of interviewees utilized in this study represented an exhaustive pool of traditional Onᐱyoteʔa·ká practitioners. The cases represented a comprehensive collection of those involved with traditional Onᐱyoteʔa·ká culture, language, and healing and provide a broad view. Importantly, most of the First Nations are unique regarding cultural beliefs, language and creation story so knowledge about any one will very likely not generalize to others. The large number of interview questions allowed for a broad and comprehensive viewpoint of how traditional Onᐱyoteʔa·ká practitioners understand symptoms that are consistent with major depressive disorder.

The numerous interview questions yielded a large data set that was difficult to analyze and interpret in a coherent manner. There was also great difficulty in translating the results of one culture into the language of another (e.g., between Onᐱyoteʔa·ká and Western academia). This was compounded by using a method that allowed all of the data to be used in analysis and then pushing those findings through a EuroAmerican framework to be acceptable for an academic audience.

#### *Future Directions*

This current study utilized extend case method as a qualitative framework for cross cultural psychological research and it would be valuable if future research extended this method to other specific First Nations. The results of this current study found some emergent themes that were not followed up on. Future research should focus on comparisons between historical and contemporary times to further delineate the strengths and vulnerabilities that a First Nation's culture has and how that manifests in



contemporary times. This would help to adapt cultural strengths into treatments for modern problems.

Results of this study revealed that loss of culture in modern times was a problem and that in historical times there was a stronger sense of community responsibility. Important follow up questions for another study would include asking, “What if there was no loss of culture?,” “Would there still be the same woman and/or the same symptoms?,” “If so, what would they be attributed to and how would they have been treated?” This would assist with determining how much the current responses were influenced by demand characteristics of this academic researcher and modern conceptualizations of mental health and depression.

Future studies may wish to determine the implications this current study has for considerations of the impacts of ethnic identity development. This may also lead to deliberation about the effects of acculturation. This current study found that the effects of contact and colonization are detrimental for the traditional Onʼayoteʼa·ká and has resulted less people following the traditions than in the past. However, it did not explore the effects that acculturation has on ethnic identity.

This study used a vignette that would be diagnosed as the mental illness, major depressive disorder using the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition-Text Revision. It was found that such a diagnostic label was not valuable due to the numerous points of access for symptom and treatment constructs and the holistic and inter-related nature of conceptualizing health that was expressed by the traditional Onʼayoteʼa·ká practitioners. There may have been other reasons that a label was not affixed to the symptoms. However, that was not explored in this study. Future

research may find it valuable to use additional vignettes such as anxiety, personality disorders, and schizophrenia to determine whether other DSM-IV-TR diagnoses are viewed differently by traditional Onlayote'a'ká practitioners. In addition, future studies may wish to include general community members and individuals seeking services as interviewees to obtain a broader perspective of illness constructs.

### *Summary*

The problem of First Nations peoples being diagnosed at extremely high rates of major depressive disorder, as defined in the Diagnostic and Statistical Manual of Mental Disorders-Fourth Edition, Text Revision (DSM-IV-TR) provided the initial idea for this project. The first question was whether a diagnostic label from Western psychology had heuristic value when applied to the traditional Onlayote'a'ká culture. This study utilized a vignette of DSM-IV-TR major depressive disorder along with interview questions to understand how symptoms of *depression* were understood by traditional Onlayote'a'ká practitioners. The findings revealed that the traditional Onlayote'a'ká system acknowledges that symptoms consistent with major depressive disorder are problematic and should be treated by an experienced practitioner.

However, the traditional Onlayote'a'ká system did not categorize mental health or even separate it from overall health. Furthermore, the Onlayote'a'ká practitioners spent less time regarding the individual and more time considering the impact the symptoms were having on wide-reaching relationships. Moreover, the Onlayote'a'ká system included constructs involving spiritual forces that could assist with the symptoms whereas the Western system largely neglects considerations of spirit and spirituality. The Onlayote'a'ká system was less behaviorally focused and included more points of access

for diagnosis and treatment than the EuroAmerican system. All of these considerations and multiple points of access for symptom constructs provided evidence that a diagnostic label such as major depressive disorder was not useful in a traditional Onʼayoteʼa·ká setting.

### *Conclusion*

This project sought to provide an understanding of the traditional Onʼayoteʼa·ká perspective on health and healing, and treating symptoms that were consistent with major depressive disorder. Even though the participants did not use a diagnostic label, they did indicate that treatment would be tied to whatever caused the symptoms. Anyone treating a traditional Onʼayoteʼa·ká person will need to understand the cause of the symptoms and underlying constructs of health in order to provide the correct treatment. A mismatch between diagnosis and treatment will not lead to the most useful and durable results.

The findings from this project likely have more use for a Western-based psychological or counseling setting than for traditional Onʼayoteʼa·ká practitioners. The traditional Onʼayoteʼa·ká culture has been presented in order to create a scene for what should be expected out of people, relationships, and creation. The foundational teachings have been summarized so that a therapist can at the very least have a point of reference when learning more about the culture's teachings. Furthermore, points of reference have been provided for understanding the different way someone involved with traditional healing views symptoms. It is hoped that other practitioners will find this way of approaching treatment will be helpful. Some information has been presented about the need to conduct a thorough assessment, and to develop spirituality. Additionally, indications have been provided about the need to refer to a cultural titleholder or seer

when needed. Any practitioner desiring to work with a traditional Onʼayoteʼa·ká person should work to educate themselves about the cultural strengths and constructs regarding health.

Traditional Onʼayoteʼa·ká cultural wellness practitioners may find use in the comparisons with Western-based psychology. Recent times have seen many people leave the traditional teachings resulting in many people not being raised within the culture. Many of the people coming to the traditional healers are adults and are learning about the culture. It is likely that Western-trained therapist have counseled at least some of the people seeking services. Some familiarity with Western-based conceptualization of depressive symptoms may aid with understanding the symptomatic person's initial point of reference.

General Native American Indian mental health theory considered the causes of *mental illness* as equated with points in time, and becoming unhealthy as a process of moving through points in time. Whereas causes in the Western system are equated with triggering events and the cumulative course, or tallying of symptoms, as the process of becoming unhealthy. The Western system focuses more on the individual and not nearly as much on the ecological as the Onʼayoteʼa·ká system. For the Onʼayoteʼa·ká, a cause is like a pebble thrown into a pond that then causes ripples to move throughout the pond. Those ripples disrupt relationships with everything they come into contact with, which creates increasing impacts as ripples intersect with other ripples. Becoming unhealthy is a process of movement as is the process of becoming healthy again. In order to become healthy again one must restore a calm and tranquil pond by rebalancing all relationships and striving for that ultimate peace through becoming harmonious with all of creation.

Divergence between these two systems is due to a difference in concepts with multiple constructs, which are the building blocks based in worldview. The Onʼayoteʼa·ká system has a broader range of diagnostic and treatment options based upon their worldview that recognizes and understands that everything is connected and that those relationships must be maintained in order to have optimal functioning. Mental illness, deficits and dysfunction are constructs that are foreign to Onʼayoteʼa·ká worldview. There is a constant striving to determine one's place within all of creation and to determine and fulfill one's purpose in life. It is recognized that each and everyone, like all things in creation, has a purpose and that no purpose is greater than any other. Everything is acknowledged as important and therefore valued. Just because someone may have a different approach to the world does not mean that it is inferior.

This can be difficult to explain and to understand. Native American Indian science and literature has been squeezed through a lens to get published and even then it is not familiar with mainstream worldview and context. One of the greatest challenges of this project was the constant changing of conceptualizing and translating Onʼayoteʼa·ká and Western construct back and forth for participants and degree requirements. It is truly impossible to translate anything one hundred percent, for as one explains a foreign concept enough to be understood it no longer means what it did in its original place. It is only an approximation of meaning until one can intuitively grasp that other reality and then realize that perhaps they lost their original anchor and the new meaning no longer means what it once did because the individual has moved to another perspective. To me it's like comparing grasping for something and holding something. My perspective

changes from when I grasp for something that is out of reach to when I finally get it and can hold it close. It is no longer out of reach; I am now able to embrace it.

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## Appendix A. Informed Consent.

### MARQUETTE UNIVERSITY AGREEMENT OF CONSENT FOR RESEARCH PARTICIPANTS Depression as Case Study Among the Oneida Mark R. Powless Clinical Psychology

You have been invited to participate in this research study. Before you agree to participate, it is important that you read and understand the following information. Participation is completely voluntary. Please ask questions about anything you do not understand before deciding whether or not to participate.

**PURPOSE:** I understand that the purpose of this research study is to better understand a traditional Oneida view of mental health and depression. I understand that I will be one of approximately six participants in this research study.

**PROCEDURES:** Interviews will be conducted to gather information relevant to a traditional Oneida view of mental health and depression. “I understand that I will be audio taped during the interview portion of the study to ensure accuracy. The tapes will later be transcribed and destroyed after three years beyond the completion of the study. For confidentiality purposes, my name will not be recorded.”

**DURATION:** I understand that my participation will consist of two two-hour interviews scheduled over eight months.

**RISKS:** I understand that the risks associated with participation in this study include feeling discomfort answering some of the interview questions. The questions are designed to gather information about the work you do, so the discomfort should not be more than what would be experienced in your everyday life.

**BENEFITS:** I understand that the benefits associated with participation in this study include no direct benefits. However, participation in this study may increase your understanding of this topic.

**CONFIDENTIALITY:** I understand that all information I reveal in this study will be kept confidential. All my data will be assigned an arbitrary code number rather than using my name or other information that could identify me as an individual. When the results of the study are published, I will not be identified by name. I understand that the data will be destroyed by shredding paper documents and deleting electronic files three years after the completion of the study. Your interview will be identified only by classification and given a code number. All data from this project will be stored in a locked office in Marquette University’s clinical psychology department for three years after the completion of this project when it will be destroyed. It is not anticipated that data from this project will be used in future studies. Your research records may be

inspected by the Marquette University Institutional Review Board or its designees, and (as allowable by law) state and federal agencies.

**VOLUNTARY NATURE OF PARTICIPATION:** I understand that participating in this study is completely voluntary and that I may withdraw from the study and stop participating at any time without penalty or loss of benefits to which I am otherwise entitled. I understand that I simply need to state to the interviewer that I no longer wish to participate. In addition, if I request I can withdraw all of my data from the project. If I do not request the withdrawal of my data, I understand that it will be used as part of the project and will be kept and destroyed along with all other project data.

**CONTACT INFORMATION:** If I have any questions about this research project, I can contact Mark Powless or Stephen Saunders, Ph.D. at 288-7398. If I have questions or concerns about my rights as a research participant, I can contact Marquette University's Office of Research Compliance at (414) 288-1479.

I HAVE HAD THE OPPORTUNITY TO READ THIS CONSENT FORM, ASK QUESTIONS ABOUT THE RESEARCH PROJECT AND AM PREPARED TO PARTICIPATE IN THIS PROJECT.

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Participant's Signature

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Date

---

Participant's Name (Print)

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Researcher's Signature

---

Date

Appendix B. Demographic Questionnaire.  
**Demographic Survey**

Gender

Male

Female

Age

18-25

26-35

36-45

46-55

56-65

Over 65

How do you racially identify yourself?

Religious Affiliation:

Please Specify: \_\_\_\_\_

Appendix C. Vignette.

Dissertation Case Vignette: Major Depressive Disorder

Adapted from: Getzfeld, A. R. (2004). *Abnormal Psychology Casebook: A New Perspective*. Upper Saddle River, NJ: Prentice Hall.

The person who comes to you is a forty-three year old woman. She has been married for 12 years and they have one ten year-old daughter. She works as an engineer and her husband works as an accountant. The woman has one younger brother who she rarely sees. Her mother is a homemaker and her father is a contractor.

When she arrives, she is casually dressed, well-groomed has glasses and a wedding ring. Her eyes are red and swollen as though she had been crying before she came in. In her words, her reasons for coming in to see you are, "It's been weird for me lately, feeling sad and discouraged all the time. It's gotten much worse in the last year. I sleep more and sometimes wake up in the middle of the night and am unable to fall back asleep. My appetite has gone. I feel empty and hopeless. I find it difficult to pay attention at work. Sometimes I think that life is not worth the constant hassle and effort. My energy is totally drained. Nothing's fun in my life." She then states that, "I came in to see what's wrong."

## Appendix D. Interview Questions.

### **Mental Health**

1. Define Mental Health or Wellness
  - a. "What might be some characteristics of a mentally healthy or well person?"
  - b. "Does the description include a lack of deficits?" "Please expand."
  - c. "Does the description include functioning fully?" "Please expand."
  - d. "Does this description include the areas of (1) affect, as in feeling sad, (2) behaviors, including psychomotor changes and not engaging in previously enjoyable activities, (3) cognition, with thoughts of death and worthlessness, as well as concentration and decision-making problems, and (4) somatic complaints, including appetite and sleep changes."
    - i. "If so, please explain that further."
  - e. "What are the implications for the community of a healthy or well individual?"
2. Mental non-Health
  - a. "What might be some characteristics of an mentally unhealthy or not-well person?"
  - b. "Does the description include deficits?" "Please expand."
  - c. "Does the description include areas of dysfunction?" "Please expand."
3. "What are the implications for the community of an unhealthy or not well individual?"
4. "How might one become unhealthy or not well?"
5. "How might someone become healthy or well again?"

### Depression Specific: (After the interviewee reads the vignette):

1. "What, if anything, is the problem?"
2. "Does she have an illness?" "If so, what is it called?"
3. "What would be the presumed causes?"
4. "What should she do about it?"
5. "What should someone else do about it, and who would that be?"
6. "What be the expected course and outcome?"
7. "When or how would she and the person treating her know when to stop treatment?"

### Extended Case Method:

1. "How did you learn this information?"
2. "How does one determine who is qualified to do this work?"
3. "Who taught you?"
4. "How might someone else learn to do this type of work?"

"Is there anything else that I forgot to ask about of that you would like to add?"

**Language interview questions:**

1. Is the culture conveyed with concepts in the language even for those who don't speak it?
2. Is there language to express severity, such as mild, moderate and severe?
3. Is there language to express pathological?
4. Is there language to express psychotic or a break with reality?
5. Is there language to express deficits, dysfunction, distress, or impairment?
6. Is there language to express remission?
7. Is there language to differentiate between short and long-term?
8. Does the language address cognitions?
9. Does the language address somatic?
10. Does the language address affect?
11. Does the language address behaviors?
12. Does the language address spirituality?

## Appendix E. DSM-IV-TR Major Depressive Disorder Diagnostic Criteria.

- A. The criteria for a Major Depressive Episode include the hallmark features of a minimum two-week period of reportedly feeling depressed, sad, or hopeless and/or a loss of interest or pleasure or not enjoying things that had been enjoyed in the past. These features will be present most of nearly every day. In addition, “the episode must be accompanied by clinically significant distress or impairment in social, occupational, or other important areas of functioning” (APA, 2000, p. 349). “The individual must also experience at least four additional symptoms drawn from a list that includes changes in appetite or weight, sleep, and psychomotor activity; decreased energy; feelings of worthlessness or guilt; difficulty thinking, concentrating, or making decisions; or recurrent thoughts of death or suicidal ideation, plans, or attempts” (APA, 2000, p. 350). The manual provides an outline of the criteria for Major Depressive Episode (APA, 2000, p. 356):
- B. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

Note: Do not include symptoms that are clearly due to a general medical condition, or mood-incongruent delusions or hallucinations.

- depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful). Notes: In children and adolescents, can be irritable mood.
- markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others).
- significant weight loss when not dieting or weight gain (e.g., a change or more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. Note: In children, consider failure to make expected weight gains.
- insomnia or hypersomnia nearly every day
- psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings or restlessness or being slowed down)
- fatigue or loss of energy nearly every day
- feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)
- diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)

- recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.
- C. The symptoms do not meet criteria for a Mixed Episode.
- D. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- E. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).
- F. The symptoms are not better accounted for by Bereavement, i.e., after the loss of a loved one, the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.